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THE DEPARTMENT OF DEFENSE VIEWS ON THE MILITARY COMPENSATION AND RETIREMENT MODERNIZATION COMMISSION'S RECOMMENDATIONS FOR MILITARY HEALTH CARE REFORM

HEARING

BEFORE THE

SUBCOMMITTEE ON MILITARY PERSONNEL

OF THE

COMMITTEE ON ARMED SERVICES
HOUSE OF REPRESENTATIVES

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HOUSE OF REPRESENTATIVES,
COMMITTEE ON ARMED SERVICES,
SUBCOMMITTEE ON MILITARY PERSONNEL,
Washington, DC, Thursday, June 11, 2015.

The subcommittee met, pursuant to call, at 3:00 p.m., in room 2212, Rayburn House Office Building, Hon. Joseph J. Heck (chairman of the subcommittee) presiding.

OPENING STATEMENT OF HON. JOSEPH J. HECK, A REPRESENTATIVE FROM NEVADA, CHAIRMAN, SUBCOMMITTEE ON MILITARY PERSONNEL

Dr. HECK. Good afternoon.

I want to welcome everyone to this hearing to discuss the Department's views on the Military Compensation and Retirement Modernization Commission's recommendations for reforming the military healthcare system.

I apologize for our tardiness. We understand there will be another vote coming up somewhere between 3:30 and 4:00. So we will try to get through as much as practically possible.

We ask the witnesses to bring their statements down to 3 minutes so that we can get to questions. And then, once the vote is called, we will determine whether or not we need to come back. It is only one vote. So it should take no more than walking time there and back if we need to continue.

As we studied the Commission's recommendations over the past 5 months, we considered the views of our current and retired service members through the organizations that represent them.

We heard mixed reviews about TRICARE and the military health system. However, the consistent viewpoint is that TRICARE can and should be improved. We take their concerns seriously and will consider all views before undertaking any changes to the military healthcare system.

That being said, I do believe that we can all agree that the work conducted by the Commission identified weaknesses in the current system that give us an opportunity to focus our efforts as we discuss reforming the Military Health System.

It is our duty, as the Military Personnel Subcommittee, to get to the root cause of the issues and help determine the best course of action to fix them. Today is the first hearing where we will receive specific testimony from the Department of Defense [DOD] on their

reaction to the Commission's recommendations to improve health benefits for our service members and their families.

I am interested in hearing from our distinguished panel if they agree or disagree with the Commission's recommendations or if they have alternative suggestions for addressing the perceived shortfalls identified by the Commission.

In addition, I am interested in hearing the Surgeons General's views on how the recommendations would specifically affect the future of the military treatment facilities and the direct care system.

As I said before, guiding consideration for our work is to ensure that we can continue to recruit and retain the best and brightest in order to maintain the viability of the All-Volunteer Force and ensuring that we do not break faith with our service members, retirees, and their family members.

[The prepared statement of Dr. Heck can be found in the Appendix on page 29.]

Dr. HECK. I would like to take this opportunity to ask unanimous consent to enter a statement from the National Association of Chain Drug Stores into the record.

Without objection, so ordered.

[The information referred to can be found in the Appendix on page 53.]

Dr. HECK. And before I introduce the panel, let me offer the ranking member, the distinguished woman from California, Congresswoman Davis, an opportunity to make her opening remarks.

STATEMENT OF HON. SUSAN A. DAVIS, A REPRESENTATIVE FROM CALIFORNIA, RANKING MEMBER, SUBCOMMITTEE ON MILITARY PERSONNEL

Mrs. DAVIS. Thank you very much. Thank you, Mr. Chairman.

And welcome to all of you, all of our witnesses, particularly those who I have known from San Diego.

And it is great to see you here, Admiral Faison.

This topic, as we all know, is very important. It is very important to the committee. It is very important to the men and women and their families who serve our country. So as we move forward toward reforming TRICARE, we have to really hold on to this, I think, and really explore it well.

We have a responsibility to ensure that we provide a cost-effective world-class healthcare system for our military. And while we have had several hearings and briefings on the Commission's recommendations, this is really the first time that we have had to hear from the Department of Defense with their thoughts on the healthcare piece.

And, more importantly, this is an opportunity to begin discussing the best way to improve TRICARE and military readiness. The Department obviously has to balance medical readiness with the rising cost of health care while at the very same time improving access, improving choice, and quality care for beneficiaries. We know that this is no easy task.

I look forward to hearing from the witnesses on how they propose that we move forward.

Thank you, Mr. Chairman.

Dr. HECK. Thank you, Mrs. Davis.

We are joined by a distinguished panel representing the offices of the Secretary of Defense in the military departments. We will give each witness the opportunity to present his or her testimony and each member an opportunity to question the witness.

Again, we would ask the witnesses to keep their spoken testimony down to 3 minutes. Your entire written testimony will be made part of the hearing record.

Now let me welcome our panel:

Dr. Jonathan Woodson, Assistant Secretary of Defense for Health Affairs and my former senior rater.

Lieutenant General Patricia D. Horoho, Surgeon General of the United States Army.

And I understand this is probably the last time that you will be appearing before our subcommittee.

General HOROHO. I hope so.

Dr. HECK. I want to say thank you for your lifetime of service and looking out for the men and women in uniform and for your passion and leadership on championing the Performance Triad.

General HOROHO. Thank you very much.

Dr. HECK. Lieutenant General Mark A. Ediger, Surgeon General of the United States Air Force, newly appointed.

Congratulations and welcome.

And Rear Admiral C. Forrest Faison III, Deputy Surgeon General of the United States Navy.

Welcome, sir.

With that, I turn the floor over to you, Secretary Woodson.

STATEMENT OF DR. JONATHAN WOODSON, ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS, DEPARTMENT OF DEFENSE

Dr. WOODSON. Thank you very much. Chairman Heck, Ranking Member Davis, members of the committee, thank you for the opportunity to appear before you today.

The Military Compensation and Retirement Modernization Commission has performed a valuable service to the Department and the Nation. We agree with their overarching findings regarding challenges facing military medicine. We concur with many recommendations and have already moved to implementation.

In fact, some members of this committee may recall that, when I testified in this room in February of last year, I talked about the need to ensure an agile, relevant, and forward-leaning Military Health System [MHS]. I stated that, to meet our mission in these changing times, I had outlined for the MHS six strategic lines of effort.

These include modernize the Military Health System management with an enterprise focus, the successful establishment of the Defense Health Agency and the development of enhanced multiservice market represent signature initiatives; two, define and deliver the medical capabilities needed in the 21st century; three, invest and expand the strategic partnerships; four, assess and refine the balance and needs of our medical force; five, modernize TRICARE health program; and, six, define the MHS's requirements in terms of global health engagement.

These strategic lines of effort will help us deliver on our overarching quadruple aim of readiness, improving the health of the population we serve, improving the experience of care in our system, and responsibly managing our costs. Our written testimony provides a more comprehensive summary of our positions on the Commission's recommendations.

For my remarks today, I would like to focus on all of the strategic efforts underway to make the Military Health System stronger, better, and more relevant for the future.

Here is what we have been working on to address the readiness requirements, ensure quality, and serve as effective stewards of the resources you have provided us:

Over the last 2 years, we have undertaken a comprehensive review of our medical infrastructure and resources and presented a modernization plan that proposes to place our most skilled professionals in the military communities where they are likely to keep those skills sharpest.

We have reformed governance and established the Defense Health Agency and have provided a collaborative and affordable way for the Department to leverage economies of scale for those functions that are common among the service medical departments.

And, third, our system is implementing recommendations that emerged from the Secretary's review of the Military Health System and culminated in the Secretary's action plan of 1 October 2014. We are making it easier for access to care in our system. We are focusing on key measures of quality and safety and participating in national quality improvement initiatives, such as the Partnership for Patients. And we are making our performance data more transparent for our beneficiaries and the public to see.

Similar to achieving historical survival rates on the battlefield, our leadership team will be relentless in our efforts to be a national leader in quality and safety in all that we do.

And, finally, we are reforming our health benefit. TRICARE is an exceptional health benefit tailored to meet the unique needs of military families. Elements of TRICARE can be improved and must be improved, and that work is underway.

We have released an RFP [request for proposal] to recompete the national TRICARE contracts, and we have included provisions that reward innovation and simplify administration of the contracts.

In summary, the Military Health System is a unique and indispensable instrument of national security. Our mission is supported by some of the most respected medical professionals in the world and attracts an extraordinary pool of young medical professionals who understand how compelling and vital this system is to others.

We are fortunate to be entrusted with serving as stewards of this system, and we take this seriously. So I am grateful for this opportunity to be here today and to answer your questions.

[The joint prepared statement of Dr. Woodson and the Surgeons General can be found in the Appendix on page 30.]

Dr. HECK. Thank you.

General Horoho.

STATEMENT OF LTG PATRICIA D. HOROHO, USA, SURGEON GENERAL, UNITED STATES ARMY

General HOROHO. Chairman Heck, Ranking Member Davis, and distinguished members of this subcommittee, thank you for this opportunity to provide the Army and Army Medicine's perspective on the healthcare forum recommendations.

After 13 years of war, the Army remains globally engaged. Any changes to the compensation and benefits must not only honor their sacrifices, but preserve the long-term viability of an All-Volunteer Force. The Army supports the underlying objectives of the Commission's health-related recommendations. However, we do have concerns regarding certain elements that threaten readiness and our medical skills.

It is critical to understand that our direct healthcare system connects with the battlefield and exists to provide health readiness to our soldiers and their families. This is what separates us from the civilian healthcare system. Our hospitals are our readiness training platforms which produce a ready medical force and a medically ready force. It is a system that performed so well over the last 13 years of war.

We concur that a comprehensive list of essential medical capabilities, or EMCs, should drive our training and resourcing. However, those EMCs must address the whole spectrum of health rather than focusing solely on combat trauma and surgical capabilities.

For instance, less than one out of every five service members evacuated from Iraq and Afghanistan were injured in battle. During Operation United Assistance, the major threats to our soldiers were endemic infectious diseases. The Army already utilizes joint structures and mechanisms to identify, monitor, and report on medical readiness. We are working to integrate EMCs into these processes; therefore, the Army does not support establishing a four-star readiness command.

The Army supports the Commission's objectives of affordable health care and increased choice for our beneficiaries. However, the Commission's recommendation to establish TRICARE Choice would negatively impact our readiness of our entire healthcare team and present financial challenges to both Active Duty families and retirees.

Currently, non-Active-Duty beneficiaries comprise 67 percent of our total beneficiary population, 83 percent of our inpatient care, and 79 percent of our high-acuity inpatient workload. These patients are vital to the sustainment of our 148 graduate medical and health professional education programs. The loss of these beneficiaries from our direct system would pose tremendous risk to our training programs and negatively impact our medical force's readiness posture.

The Army sees financial risk to soldiers and to families and injured in the Commission's recommendation to offset TRICARE Choice costs through a basic allowance for health care. Year-to-year healthcare expenses are unpredictable, and many areas of our country are medically underserved.

In conclusion, the Army needs a medically ready force. When the gate on the Stryker opens, commanders need to know that it will be full of soldiers that are ready to deploy. And the Army needs

a ready medical force. When the wounded soldiers hear the rotor blades of a medevac [medical evacuation] helicopter, they need to continue to have confidence that our providers are trained and ready. Any radical departure presents significant risk to a system that has produced record levels of both combat casualty survival and readiness.

I would like to thank the Congress for your continued support. Army Medicine team is proudly serving to heal and honored to serve.

Dr. HECK. Thank you.

General Ediger.

STATEMENT OF LT GEN MARK A. EDIGER, USAF, SURGEON GENERAL, UNITED STATES AIR FORCE

General EDIGER. Chairman Heck, Ranking Member Davis, and distinguished members of the subcommittee, thank you for inviting us to appear before you today.

The Air Force is truly grateful for the hard work of the Military Compensation and Retirement Modernization Commission. Many parts of the Commission's recommendations will enhance and facilitate programs that serve our airmen, their families, and our veterans.

Today I will speak to impacts in two areas of primary importance for the Air Force based upon our analysis of the Commission's recommendations. I will begin with the impacts on the readiness of our medical force.

We appreciate the Commission's focus on the linkage between care provided in our hospitals and the readiness of our medical force. We found their proposal to identify and quantify readiness-related essential medical capabilities helpful to focus efforts on the capture of specialty care for our hospitals. That concept builds upon the Readiness Skills Verification Program we have utilized in the Air Force for over 15 years to set clinical standards for the readiness of our medical force.

However, we do not see the need for a joint readiness command, as existing processes jointly utilized by the services enable us to measure and assess the readiness of our force.

We have significant concern about the impact the Commission's health plan recommendations would have on the readiness of our force. We believe the proposal would shift family member and retiree care significantly to the private sector and thereby move care essential to our readiness out of our medical facilities.

We also believe the proposal to place our medical facilities into competition with the private sector would drive up administrative costs and significantly detract from the focus on the operational mission in our medical facilities.

The second area of primary concern centers on our support to Active Duty families. We believe resilient families with excellent health service support greatly enhance the resilience of all of our airmen. We support changes in the President's budget to improve TRICARE while enhancing our readiness.

Additionally, significant progress in the strategic line of efforts referenced by Dr. Woodson has occurred, and we are a progressive system of health and readiness as a result.

We are concerned that the Commission's proposed change to the health plan would increase stress on airmen and families by requiring them to navigate a complex insurance marketplace on a recurring basis. We are concerned that the Commission's proposal would shift family care significantly into the private sector, thereby creating a hole in the safety net commanders depend upon for Active Duty families under stress.

Proper balance in the mix of our medical force is important to maintaining a ready medical force while providing safe and high-quality health services. The National Defense Authorization Act of 2010 permanently prohibited the services from converting non-military essential Active Duty medical positions to civilian positions. Relief from this prohibition would enable the Air Force to judiciously increase the proportion of civilians in its force mix.

I thank the committee for your continued support for Air Force medicine and the opportunity to answer your questions today.

Dr. HECK. Thank you.

Admiral Faison.

STATEMENT OF RADM C. FORREST FAISON III, MC, USN, DEPUTY SURGEON GENERAL, UNITED STATES NAVY

Admiral FAISON. Chairman Heck, Ranking Member Davis, distinguished members of the subcommittee, thank you for the opportunity to appear before you today.

The Navy appreciates your leadership in establishing the Commission and commends the Commission for their thorough and independent assessments. We remain guided by our Navy Medicine's strategic priorities of readiness, value, and jointness.

We note that the Commission recognized the importance of these imperatives and many of their overarching objectives are largely aligned with our strategic priorities.

Following the release of the Commission's final report in January, Navy Medicine participated in the DOD-led rapid and comprehensive review of the healthcare recommendations. While there is general support for the underlying objectives of the recommendations, I will briefly highlight some of our perspectives and concerns regarding them.

In relation to medical readiness, we do support establishing common and service-specific essential medical capabilities, or EMCs, as they could be an effective means to monitor readiness and guide resourcing decisions.

We note, however, that EMCs must be developed for more than just surgical trauma skills. Military medicine supports a wide range of operations, including treating disease and non-battle injuries during military operations as well as providing humanitarian assistance and disaster relief when called upon in crisis.

While there is general agreement to the Commission's objective to provide an affordable health benefit with additional choice, we must recognize that our medical centers, hospitals, and clinics are our most important readiness training platforms for our military medical personnel and critical to sustaining vital skills and clinical competencies of them. The availability of case mix, volume, complexity, and diversity is vital to having a trained and ready medical force.

In this regard, care of our beneficiaries is inextricably linked to our readiness mission. Patient enrollment is fundamental to our approach to maintaining the health of our patients. The Military Health System is working hard to recapture workload into our direct care system and leveraging initiatives like our Patient Centered Medical Home program to improve access and care.

Navy Medicine is leading forward in these areas as they continue to show progress. We believe that the Commission's approach to offer greater choice through the use of commercial insurance plans presents risk by reducing patient volume and case mix in our system and positioning MTFs [military treatment facilities] at a significant disadvantage in attracting patients when competing against commercial insurance plans.

The careful assessment of the recommendations for exceptional family members requires additional time. We agree with the objective of expanding services to help family members with specific needs, but more work is needed to identify which specific services among the many State Medicare waiver programs most meet their needs.

Regarding the DOD and VA [Department of Veterans Affairs] recommendations, we support the goals of the Commission, but we believe that the current joint executive committee has sufficient authorities to realize the outcomes desired by the Commission.

Throughout Navy Medicine, we work closely with the VA in assessing opportunities to collaborate and cost effectively share services to meet the needs of service members and our veterans, and we have several unique collaborations, sharing agreements, and partnerships already in existence that benefit both Department beneficiaries.

We are working with the Assistant Secretary of Defense for Health Affairs, the Defense Health Agency, as well as our sister services to incorporate many of these opportunities in the MHS. Some changes can be accomplished within existing policy, while others may require legislative changes for which we would appreciate the Commission's and the committee's support.

In summary, we recognize we need to recognize what sets us apart from civilian medicine, that we are a truly rapidly deployable, fully integrated medical system. This capability allows us to support combat casualty care with unprecedented battlefield survival rates, to meet global health threats as we recently did in deploying labs and personnel to Liberia in response to the global Ebola crisis, and to our hospital ships, *Comfort* and *Mercy,* deployed today and underway supporting missions around the world.

We must also understand that our readiness mission is directly linked to the training and skill sustainment our personnel do every day in our hospitals, in our clinics, in our labs, and in our classrooms. We cannot expose our direct care system to risk that could negatively impact our readiness posture. Thank you very much.

Dr. HECK. Thank you all for your testimony.

We will now begin a 5-minute round of questioning from each member. I will defer my questions to the end and recognize the junior member of the subcommittee, the gentlelady from New York, Ms. Stefanik, for 5 minutes.

Ms. STEFANIK. Thank you, Mr. Chair.

And thank you to all of our witnesses here today.

I wanted to focus and address my question to General Horoho. I represent New York's 21st District, which is home to Fort Drum, and part of the 10th Mountain Division is based at Fort Drum.

Later this summer I plan on hosting a listening session with various service members and their families to hear their feedback on the Commission's reports and healthcare plans going forward.

And Fort Drum is unique, as you know. There is no hospital on post and we have a very strong partnership with civilian hospitals like Samaritan and River Hospital. I think you visited Fort Drum recently to assess——

General HOROHO. Yes, ma'am.

Ms. STEFANIK [continuing]. That partnership.

Could you talk about whether there will be an impact for Active Duty service members because of that unique relationship, because there is no on-post hospital.

General HOROHO. Thank you, ma'am.

If I understand the question correctly, are you asking whether or not there would be an impact if we move towards the Commission's recommendation on Fort Drum?

Ms. STEFANIK. Correct.

General HOROHO. Okay. I do believe there will. And the reason why I say that is that right now many of the readiness skill sets even though we have a unique capability there with the clinic and then we have a strong partnership with the civilian facilities, we still rely on a large family member and retiree population getting their care at Fort Drum proper.

That allows us to enhance our readiness skills of our medics as well as our clinicians, our orthopaedic surgeons, and the entire healthcare team. If that population goes out to one of the 11 different plans that are out there, then we become competition with the healthcare plans and it is an unpredictable population that we would be able to treat.

Ms. STEFANIK. Great. Thank you very much.

And then I just wanted to ask broadly: Can each of you talk about the kind of listening sessions that DOD has done to understand the concerns directly from the service members. I know this is a large question. Just broadly, if you can answer that.

Dr. WOODSON. Sure. Let me start, and I will let the Surgeons General follow on.

Just, you know, briefly, coming out of the MHS review, we conducted town halls. Of course, we routinely, in fact, use survey techniques to find out what is going on.

And for the sake of brevity, I would just say that the Evaluation of the TRICARE Program: Access, Cost, and Quality, the 2015 report to Congress, contains a lot of good information about what we do to survey our population to adjust the program and understand where we are at and where the improvements are needed. And I would just recommend that to you.

General EDIGER. Yes. In addition to what Dr. Woodson referenced from the MHS review, which was very valuable and helpful, each of our medical group commanders has a panel in which they conduct regular listening sessions of people who consume their health services in the local community.

We have a process by which the findings and the trends from those sessions are fed up and centrally analyzed for trends, and we found that to be a very helpful process.

In addition, each of our medical groups uses social media to solicit input and feedback from the people that consume their health services, and we also use social media centrally for that purpose.

Ms. STEFANIK. Great. Thank you very much.

Did you want to add?

Admiral FAISON. Yes, ma'am.

Same in the Navy. We conduct regular town hall meetings. We have an expectation that all of our COs [commanding officers] will regularly attend the healthcare consumer councils at each of our bases. And whenever we travel, we make a point of meeting with every line commander to solicit their input. We also are very active on social media to get feedback in.

General HOROHO. If we are going to go all the way, I will do the same thing, then, because we are very similar in our approaches.

The other is are virtual town halls that actually are conducted from the Chief of Staff of the Army on down to get the feedback from our beneficiaries and being able to hear their voices and the concerns.

We have also had high-reliability summits to be able to educate our Active Duty professionals in the healthcare business. And then we take that back to the commands and then they share information with the beneficiaries as well.

Ms. STEFANIK. Great. Thank you very much.

I yield back.

Dr. HECK. Thank you.

Mrs. Davis.

Mrs. DAVIS. Thank you, Mr. Chairman.

And I appreciate, again, all of you being here.

I am not sure if my questions are related. Probably are.

But, first, you did talk a little bit about the loss to the beneficiary because, if—in the Commission's recommendations, we had a different system, and training of medical personnel was critical to that.

So I wanted to ask about that, but also about the fact that the Commission determined that EMCs, the essential medical capabilities, are not clearly defined and they suggested that the DOD had not established the clinical proficiency standards for military medical personnel in facilities based on widely accepted metrics.

So, you know, you may not agree with that assessment, but I wanted to know how you see that assessment and what you would propose. And if you can attach it to training, that would be great, but maybe that is a totally different question. So——

Dr. WOODSON. Yeah. Maybe I can start and, again, the Surgeons General can add on.

From a context point of view, one of the things we have to understand is that medicine really has evolved. So four decades ago a doc [doctor] may have been a doc and a nurse may have been a nurse and today, with sub-specialization, the idea of what the competency is and how to maintain that competency is radically different.

And so the issue, really, that we got to, again, as part of the modernization study and some of the self-analysis we were doing

is identifying what the specifics of the skill set should be by specialty and military occupational skill set. And this is a really big work, but important work to do so.

We self-identified, prior to the Commission, that we needed to focus on this issue of better defining readiness, competency, and being able to measure that. I think the Surgeons General have done a great job, and the Air Force, I think, has a great matrix that they use. And the other services have their metrics as well.

General HOROHO. Thank you, ma'am.

We have looked at this over the last 3 years—this has been a culture shift across Army Medicine—and really looked at our hospitals as being our readiness training platforms because that is where we house our graduate medical education programs and our health professional education programs.

So we rely on a constant beneficiary population that gives us the complexity and the case mix. We evaluated where we had our Active Duty, that there was a mismatch a couple of years ago where our green-suiters were. They were in more of the smaller areas, and then we had contract personnel and civilians more in the medical centers.

Those medical centers are where we need that complex capability and readiness skill set training. So we have started migrating and shifting where our Active Duty population is.

We have also looked at it from not just combat casualty care, but actually the readiness skill sets that are needed for every single one of our service members that are part of the medical team. And so I will give a good example. We looked at substitutability.

So we may have rheumatologists that we need for our day-to-day healthcare beneficiaries, but for deployability, we are identifying what are the wartime skill sets that are needed for that specialty so that they can be substituted for a surgeon on the battlefield. And so we are now down to that level of detail of really looking at it.

And, in addition to that, we now have standards in place where I can assess the readiness of my military treatment facilities, I can assess the individuals. And now we have just rolled out, with all three services using it together, a surgical tool that allows us to look at every one of our operating rooms, the number of cases that are needed, the complexity, and then being able to look at that in addition to assessing our surgeons.

Mrs. DAVIS. Thank you.

I think I will go ahead and have the Surgeons respond.

And I think part of my question around this, too, and the whole issue I know Admiral Faison will and I talked about this a lot in San Diego because, you know, there is this concern—and it is partly why the Commission addressed this—in the mix in terms of the patient population and the ability of medical professionals to have access to be able to help those and treat those who are coming from a more diverse and a larger population.

And so I guess I am just trying to get at that as well in terms of whether the mix that you have is adequate to do that, since we also are looking at the general public to help with that. We know that military medicine is not going to be able to support that always and——

General EDIGER. Yes. An important point is that, when we talk about essential medical capabilities and clinical currency, we are talking about that within the context of readiness, the clinical skills that are needed in a deployed environment, which don't always exactly match up with our day-to-day practices at home station.

And so, in the Air Force, we have had a process that, by specialty, we actually define case volume and mix and skills that actually translate into the deployed environment, and then we keep records and we track the extent to which we are able to meet those requirements and keep clinicians ready.

In some cases—you are right—our population doesn't really have the demand in certain procedures that would support our readiness requirements. And so, in the Air Force, we have used strategic partnerships in some cases—and the other services have as well—to send selected clinicians to other places under training agreements to make sure they are current in those types of skills.

I think what we have all decided to do together is to actually incorporate these standards for clinical readiness into the measurement of the preparation and readiness of our forces and present that jointly the same way our combatant partners in the line present the readiness of their forces.

Mrs. DAVIS. Thank you.

I know my time is up. Thank you, Mr. Chairman, for those additional minutes. Thank you. We will get it later.

Mr. JONES. Mr. Chairman, thank you very much.

And, Dr. Woodson, I read your letter on May 19th, and I would like to make reference to that.

First, I would like to share with you and the panel an email from a marine's wife down at Camp Lejeune, which is in my district, and I will start with this from her email. "2 weeks ago, on April 13 of 2015, he attempted suicide. He has severe PTSD [post traumatic stress disorder], a TBI [traumatic brain injury] because of an IED [improvised explosive device] explosion, and has severe physical ailments associated with the blast. He was placed on a ventilator for about 12 hours as a precautionary while the pills he had overdosed on worked their way through his body while he was sedated and unresponsive."

The reason I wanted to bring that forward is because many of us, not all, but in Congress, including Senator Vitter, have been very supportive of an option that we would hope that the Department of Defense would give to the medical doctors in all services, should the doctor decide that maybe hyperbaric oxygen treatment [HBOT] might be a way to treat PTSD and TBI.

I asked in the letter I wrote you that you respond and not Admiral Wagner. We had written Admiral Wagner and asked that the hyperbaric oxygen treatment—that Admiral Mullins himself go to Camp Lejeune, remain there and be put in the Intrepid Spirit Concussion Recovery Center at Camp Lejeune. Obviously, his response back was not very encouraging. So let me go to this paragraph.

"How much money was expended by DOD on medication in 2014 to treat PTSD and TBI for Active Duty military? As we note, certain medications have been implicated in the suicidal epidemic in our veterans. Are you aware that Dr. Harch published a statistical

significant reduction in suicidal ideation in the HBOT-treated veterans and this was accomplished in veterans with the combined diagnosis of TBI and PTSD? Do you have any DOD studies showing the same with any other therapy?"

I don't expect you to answer that today, but I am looking forward to your answer.

What is so ironic to marines down at Camp Lejeune is that, in this Intrepid Center, they can be treated with yoga and acupuncture, but they can't be treated with hyperbaric oxygen.

To many of us in both parties, House and Senate, we just don't understand why and how that the Department of Defense in their studies say that they do not see where hyperbaric oxygen treatment would be a positive.

And, yet, Dr. Harch, who is a foremost expert at LSU [Louisiana State University] on this treatment, has even offered—and I have written to Secretary Mabus—that he will take 12 marines from Camp Lejeune at no charge to DOD and LSU will absorb it to treat them for 8 weeks. And I hope that you will take the time to read carefully what we are asking you.

As you know, Senators Vitter and Landrieu asked on Inspector Jones' investigation as to how the Department of Defense—the different studies have studied hyperbaric oxygen and why they do not think this would be helpful to those with PTSD and TBI.

So I hope that you will answer this letter. Again, it was May the 19th. And I want to give you, as I would anybody, 6 to 7 weeks to respond back.

But when you read—I have never heard of any, any, soldier or marine or anyone that had the treatment of hyperbaric oxygen that committed suicide. Yet, when they are medicated, we are averaging maybe 20 or 21 a day committing suicide.

I don't understand, sir, why this treatment will do no damage—if it doesn't do any good, it doesn't do any damage. I guarantee you it will do more good than yoga or acupuncture.

Will you promise me today and this committee that you will respond back to this letter that we have written here?

Dr. WOODSON. Absolutely.

Mr. JONES. Thank you, Mr. Chairman.

Dr. HECK. Mr. MacArthur.

Mr. MACARTHUR. I pass.

Dr. HECK. Okay. So we had a briefing from the current TRICARE administrative service organizations [ASOs] on how they viewed the Commission's recommendations. Obviously, they all have a non-military health insurance option that they also provide, and they stated that they felt that there would be opportunity for them to address some of the shortfalls or deficiencies identified by the Commission if they were just allowed to utilize some of the best practices that they have on their non-military side on the military side. This is moving away from fee-for-service to value-based care.

So, Dr. Woodson, I know we have had this discussion a little bit offline. You know, as the TRICARE 2017 contracts, RFP, is out, what would be the pathway to be able to, one, provide the authorities necessary to allow some of what is being done on the civilian side to come into the military side as far as managing health care?

And how would that happen if the TRICARE 2017 contracts are let prior to those changes being made? Would it be a mod? Is there a benefit to just extending current contracts till we figure this out? What do you believe is the best way forward?

Dr. WOODSON. So thank you very much for that question. And we fully endorse moving toward utilizing value-based care in the management of both the TRICARE contracts and our patients to their betterment.

As we move to 2017, again, we have approached it in a more disciplined way. And, in fact, we are looking for the authority to use value-based care.

Now, as it relates to the flexibility, remember, there is a common misperception about the contracts that they are kind of 5-year locked-in entities. They are not. In fact, they are 1 year with yearly options. And we modify contracts all the time.

Continuing the extension of current contracts is costly and, in fact, it just maintains sort of antiquated systems. And so, as we move more to trying to use utilization management tools, big data to better define and manage our populations, it is very important that we modernize the contracts. But we can incorporate all those things and fully anticipate incorporating all of those issues into the 2017.

And, lastly, we have already moved out in terms of value-based care. We have a demonstration project right now in Maryland in which we have a pay-for-performance model.

And, lastly, we are working very closely with Medicare on their work group, but to define particularly those outcome parameters that are important in making sure you have success with value-based care.

Dr. HECK. Great. That is very encouraging.

I look forward to continuing to work with you to make sure that DOD has all the authority it needs to be able to capitalize on some of these proven strategies that are currently forbidden or prohibited from being utilized in the military healthcare system.

One of the other areas that was brought up is, of course, the importance of patient data and data analytics. And, you know, it seemed like there was a disconnect in being able to have all the data to adequately manage a patient's care when the prescription part of TRICARE is not part of any one of the ASO's service lines.

And it was brought forward that perhaps and, as I understand it, prior to my arrival here, it was Congress that said, "Go ahead and go out and get us a separate PBM [pharmacy benefit manager]."

But the idea of bringing prescription service back within the ASO contracts, thoughts on that?

Dr. WOODSON. Well, I think it is very important, I guess, to address the central point of making sure there is single point of accountability for the coordination of all of the benefits and care, and that is one of the issues that concerns me about the Commission recommendation.

So if you look at what would have to happen, we would have to disestablish the DHP [Defense Health Program], disestablish TRICARE. We would have to have OPM [Office of Personnel Management] establish this choice network with navigators because it

would be very important. They would have 250 programs which the service members and beneficiaries would have to negotiate.

We would have to expand the MERHCF [Medicare-Eligible Retiree Health Care Fund] fund to cover the healthcare and pharmacy programs for non-Medicare-eligible retirees. Funds from the services' MILPERS [Military Personnel] would have to be transferred to the employees' health benefit fund managed by OPM for Active Duty family members, Reserve Component and family members.

For gray-area retirees that is non-Medicare, funds should also be transferred from MERHCF to the employee health benefits fund managed by OPM. We would have to establish a new trust fund which would be managed by DOD to finance existing pharmacy and dental programs for Active Duty family members and Reserve Components.

MTFs would be funded through a revolving fund and using reimbursements that they receive for care. And the services' O&M [Operations and Maintenance] accounts would be at risk for shortfalls, and we estimate that would be about $2.4 billion a year. And we would have to establish a catastrophic fund for Active Duty family members.

Now, the key here, though—and then DOD would still be responsible for pharmacy, dental, vision, the basic allowance for healthcare, the networks for Active Duty service members, the networks for overseas Active Duty service members, which there is no mention of how we would handle that in the Commission report, ECHO [Extended Care Health Option].

And so the important issue here is that, if you take it from the point of view of the beneficiary—and let's just say, for example, we take an Active Duty family with an exceptional family member, a child with autism, let's say.

They are going to have to deal with these private insurers for the health care and then they are going to have to deal with us for other things. And if they have cost overruns, then they are going to have to try and get into this catastrophic fund.

That is a lot of touchpoints. And then, if you add to that the highly mobile population we have, I think that there is substantial risk when you don't have a single point of accountability for the entire health benefit, substantial education for retirees, substantial education for beneficiaries.

So I think there are some risks, and I think there are easier approaches to reforming TRICARE to make it exceptional. And I think that is where we would love to work with Congress.

Dr. HECK. Great.

We will go for a continued round until we get called for votes. Mrs. Davis.

Mrs. DAVIS. Thank you, Mr. Chairman.

And perhaps, Dr. Woodson, I can pick up on that. And I hope the others will join in, too.

One of the things that we heard with the Commission was I think they were a little displeased, actually, when they heard that there was a kind of protectionism coming through, that surely our military families might not be able to navigate on multiple systems

like this. And I think you all said as well that, you know, it is harder to navigate a more complex system.

So I wonder if you could respond to that a little bit because I understand exactly what you are saying, how important it would be to have a point of accountability. But at the same time there was a sense that somehow we couldn't provide the support system to enable families to be able to utilize that to the best of—you know, to serve their needs.

And if you can expand on having more options for families, more choices, as they talked about, that seems to be a good thing, and maybe we shouldn't get caught up in whether or not they can navigate it.

So help me out with this a little bit because I don't think that is really the reason to not do this, of course, but——

Dr. WOODSON. I am sure the Surgeons General will have—that is a great question, and the Surgeons General will certainly want to say something about this.

But let me just say this, that when I go out and talk to folks and when I look at surveys, choice is not about wanting to navigate through 250 health plans.

Choice, as expressed to me, is ensuring that I have a robust health benefit that will take care of my health needs when I want it, and then the real choice is about being able to see the provider that I want when and where I want them.

And so if you look at PB [President's budget] 2016 and 2015 proposal, it was about giving more choice to the family member so that they wouldn't have the hassle of authorizations and referrals and they could choose when and where they wanted to see, you know, the doc or the provider. That is, I think, the choice that they want, not necessarily a lot of programs.

By the way, when you boil it down and you go into the commercial market, you really find three types of programs. Right? You find health maintenance organizations, which is similar to our Prime. You find fee-for-service programs of two types. One is preferred provider and one is, again, more open fee-for-service. We have those, basically.

So they are not going to have really different choices in terms of types of plans. They are just going to have to navigate through more insurance programs and not have a single point of accountability.

Admiral FAISON. Ma'am.

General HOROHO. Yeah. Go ahead. And we will go backward.

Admiral FAISON. I will address the most difficult case for the Navy. Thirty-five percent of the Navy is deployed in any given day, and 75 percent of our sailors were born after 1986. They are very young.

And so the typical sailor is married with two children. So they are stationed, let's say, in San Diego. The ship is out at sea. Right now, if that family member has a problem with their health care, they call the CO [commanding officer] of the hospital. It is one point of contact.

So I want to distinguish between navigate versus advocate. And so, if there is an issue, they call one person. If we allow them the choice, they are navigating several hundred health plans, as a CO

of a hospital, having just been one, I have no leverage over those plans. So how do I advocate for that mom and her children?

And if one of those children is a special needs, she is dealing with the health plan for part of her healthcare needs, she is dealing with DOD for the special needs part, she is dealing with DOD somewhere else for pharmacy. It is overwhelming while you are trying to balance two kids as a single parent and your grandparents are back in Texas, as an example.

So we are worried that we are adding to the plate of our service members to get a benefit where right now they have got kind of a single point of contact to pick up the phone and help them.

Mrs. DAVIS. And, of course, we know a lot of those are ombudsman as well——

Admiral FAISON. Yes, ma'am. Absolutely.

Mrs. DAVIS [continuing]. That single point of contact. And it is wonderful in San Diego.

Sir.

General EDIGER. I would agree with that completely. It is not that we think the families are incapable of navigating. We just see the complexity of it as another source of stress for families that we know are already under stress by virtue of the service and the OPSTEMPO [operations tempo] that they are a part of.

I think the other thing that would be challenging in that venue is that, if we have families who have a variety of different health plans that they have chosen on the marketplace, those plans come at different prices. They will have different ranges of benefits.

And so we have a remarkable system between all three services of employing the medical home concept in the way we provide primary care. And so with that comes timely prevention in a coordinated team-based approach to care.

That becomes more difficult to apply if you are dealing with a patient population that has got a variety of different types of health coverage.

And so we think we can do a better job of providing continuous support to their health and performance over the time of their service to the Nation if they are getting their care continuously in our MTFs.

General HOROHO. And, ma'am, in addition to that—because we are pretty similar in all of our responses—I think the importance of the care coordination can't be understated, especially when service members are deployed.

And when we looked at the area with behavior health, one of the things that we realized is we had to be very unique in the way that we supported families or children that had stressors due to the deployment. So we took our behavior health and we are able to embed them into the school-based programs.

When they are out into the civilian sector, those types of unique options are not going to be available to respond to really timely needs.

And I think the other piece of it is, as we realize when health care is changing or opportunities to be able to be much more responsive in the area of health, that allows us to employ all of our capabilities together using tele-capabilities to really reach our patients where they need their care.

Mrs. DAVIS. Yeah. Thank you.

Thank you, Mr. Chairman.

Dr. HECK. Mr. MacArthur.

Mr. MACARTHUR. Thank you, Mr. Chairman.

I am sorry I missed your opening remarks. I would have been very interested in hearing them. But a lot of the discussion on this part of the Commission's recommendations has been around the quality of health care to our military families, and rightfully so. And that is why the four of you are here with that focus.

But some of the Commission's focus was on the financing of health care, and that has given rise, I think, to a lot of the recommendations.

And as I think about that, the financing of it, the creation of a structure, and they have gone down the private route, and I think there are other views that fixes to TRICARE would be a better approach to that, I worry about the next iteration.

So we make fixes now and then the broader marketplace continues to evolve and new programs allow the non-military healthcare world to make changes and get efficiencies and TRICARE is stuck in whatever new model we create. And so my question has to do with how we create a self-evolving TRICARE.

Let me explain what I mean with that. Something that doesn't require an act of Congress every time we want the program to be able to keep pace with what is going on in the marketplace. And I think this concept is essential, and this is why I have been somewhat supportive of the private market idea, although I think there is problems with it.

And so I am now back in my thinking to what do we do to TRICARE so it can evolve. Without you coming and getting 435 members, you know, half plus 1, to agree to that, I would be interested in your insights on that.

Dr. WOODSON. So let me start again, and the Surgeons General can follow on.

That is an excellent question. That really is the heart. So one of the things I think we all need to consciously understand is that TRICARE is not an insurance program. It is a defined Federal benefit program in which it is guided by laws and statutes and the like. And that was probably very appropriate two decades ago.

What we need to, again, I think partner on is giving the flexibility to the administrators of the program to evolve the program in real time to take advantage of what's occurring in medicine.

So I was very thankful to Congress when last year they gave me the ability to look at evolving medical technologies and implement them without coming to Congress right away, and that was just new. That is new. But it is that kind of thinking.

You know, I had this discussion with some folks, and it had to do with something we wanted to do with TRICARE. And the lawyers at the time were telling me, "No. You can't do that. No. You can't do that." And they were well meaning—don't get me wrong—about this.

But I said to them, you know, "Someone once said that the law should be stable, but never static. But medicine is neither stable nor static. And so we have to understand that and build in the flexibility."

Now, you, as Congress, in your rightful authorities and position, should have oversight. And so what we owe to you is a mechanism for bringing to you what we have done and being accountable for what we have done, but we need to have the flexibility to modify and approve the program to make it, again, the exceptional program that the beneficiaries deserve.

Mr. MACARTHUR. If any of you know, how many lives are covered by TRICARE today?

Dr. WOODSON. 9.5 million.

Mr. MACARTHUR. I mean, that is bigger than many, many health insurers. That is a lot of lives. One would think that we should be able to create a form of TRICARE that is competitive with anything——

Dr. WOODSON. You bet.

Mr. MACARTHUR [continuing]. That the private market can offer and that can evolve just like the private markets evolve.

And I would encourage a continued dialogue because I think there is the potential for that that could possibly overcome some of these hurdles that—and, as I said, I started as—we have had these discussions—I started as an advocate for change, but sometimes the—you know, sometimes the cure can be worse than the illness. And so I think maybe we need to explore this more.

I yield back. Thank you.

Dr. HECK. Thank you.

And I want to go back. Dr. Woodson, thanks for, you know, pointing out all the things that the Commission would require you to do to set up this new program.

And as we move towards the idea of value-based care and having that single point of accountability and contact for a patient in a medical home, it goes back to the previous question that I had, which is: Is there, you know, benefit in looking at—do we bring pharmacy benefits back in-house to the TRICARE ASOs, the nurse advice lines, which right now don't go to the ASOs, so you have somebody calling for nurse line advice that is unrelated to the actual healthcare provider they are going to wind up seeing?

So I think, as my colleague said, as we evolve and try to maximize the benefits of what has happened on the outside of the military healthcare system, again, we need to come up with how do we give you the authority to be as flexible and agile as you need to be. Right?

And to the Surgeons General, a topic we haven't discussed yet: Your opinions on the idea of a unified medical command. What do you think are pros versus cons, in 3 minutes 58 seconds?

General HOROHO. Let me go quick.

The Commission actually recommended a joint readiness——

Dr. HECK. We have taken that one off the table.

General HOROHO. You have taken that off. Okay.

Dr. HECK. We are just taking about specifically—kind of like a TRANSCOM [Transportation Command] for medicine.

General HOROHO. You know, I think right now we have spent so much time and energy and we are starting to see some progress in the 10 shared services.

I think we need to allow that to continue to progress. We have really worked with standardizing our capabilities and looking where we need to be more interoperable.

And so I think there is some goodness in cost savings and, also, just standards that will be common across the board to decrease unwarranted variance.

So I support the direction of refinement of where we have been going with the Defense Health Agency and then common business processes across the board.

General EDINGER. Yes, sir. I agree.

I think, if you look at what has happened over the past 3 years, there have been substantive change in the Military Health System. We have worked together jointly under a new governance process.

We have stood up the 10 shared services with the Defense Health Agency to gain efficiencies and effectiveness in what we do in common. We train our enlisted out of a joint platform. We have a medical school where our physicians train together. And we have a lot of our hospitals now, more than ever, that are jointly staffed.

So I think what you are seeing is a significant evolution in the way we work together jointly in our home station medical support.

Admiral FAISON. Sir, I would agree with that.

You know, we have been doing this for a long time. All our IT [information technology] systems are architected jointly so that, no matter where you go and what facility you are in, your healthcare record is available.

We deploy our staffs together. You know, when I was deployed in theater running a combat hospital, I was commander of a joint task force. I had Army and subordinate Air Force units working for me. We worked together side by side.

In San Diego, when I was in garrison, all the wounded warrior care physical medicine rehabilitation was provided by Army physicians. We trained Air Force pediatricians.

We have been doing this. And now we have evolved to these shared services. I would recommend we give these an opportunity to mature and then step back and say, "What problem are we solving?"

Dr. HECK. And, General Edinger, thanks for putting out a plug for Uniformed Services University, one of the finest medical schools in the country and no better military medicine school in the world. I was on faculty there for 4 years.

Mrs. Davis.

Mrs. DAVIS. Thank you, Mr. Chairman.

I might just ask if you are seeing any outstanding cultural issues in that integration as you move forward with jointness.

Admiral FAISON. Ma'am, I will address that.

I had the privilege of visiting San Antonio for our combined enlisted training program that we run for all our "A" school corpsmen, our medics, our technicians, and they all get their training together now. And although we preserve our service cultures, we teach our corpsmen how to salute and the different signal flags and things like that.

What really impressed me the most was, when I looked down into the courtyard, I saw Army, Navy, and Air Force young, junior enlisted folks working together, making friendships and bonds that

were going to carry them throughout their careers. I have not seen service cultures, you know, we have the banter that goes back and forth where I am trying to learn how to say "Hooyah" and at the same time how to teach my Army colleagues how to say "Ooh Rah." But when push comes to shove, when we are at the bedside, we are taking care of the patient as one team. I haven't seen cultural issues.

General HOROHO. If I could just give an example, when the issue came up with the capabilities that needed to deploy in support of the Ebola mission, it was all three services coming together and saying, "Let's look at how do we do this jointly."

We looked across our facilities, as Surgeons General, and identified the capabilities that were needed. It was a tri-service effort. We went down to San Antonio. It was all services coming together, developing the training plan.

And then they were ready to support that mission. That is a whole different way in which we have approached those types of missions.

General EDINGER. I agree.

We have learned that culture is important because we are part of a mission. And so, when we deploy our medical folks out to work within our missions, they need to be able to work within the culture of our service.

But at the same time we have learned that culture should not and does not get in the way of the way we take care of our patients. And so I think we have learned how to strike that balance appropriately.

Mrs. DAVIS. Thank you.

Dr. HECK. Mr. MacArthur.

Mr. MACARTHUR. I would like to continue that discussion that I suggested a few moments ago, and it is how can we give you more flexibility today.

In broad strokes, are there two or three things that we could do now structurally that would give you the flexibility not to propose programs that we then approve, but give you the freedom to explore, to act, to try things without an act of Congress, you know, those broad changes? Are there things we could do today that would allow you to change the current program?

Dr. WOODSON. So thank you again for what I think is an extraordinarily important question.

So in the spirit of, again, medicine isn't stable, we need to develop legislation that gives authority, I think, to the Assistant Secretary of Defense to define a process for evaluation involving medical technologies for inclusion in the program and then include them, even if it requires subsequent follow-up evaluation of their efficacy at some point in time in the future.

And that ought to be broad. I think that is really very important because, again, medicine isn't stable. New ways of treatment evolve every day. And the way the language reads now, it is pretty rigid about the requirements for evidence, and that sort of stalls us a little bit.

I think there are some other things that we need to deal with to synchronize our efforts. One of the things that the Surgeons General and my office have come together on is looking at new

models in which we can manage markets, optimize the use of the military treatment facilities, and optimize the use of the purchase care market.

And so there are going to be some new, I think, authorities that we'll need to allow patients to flow from the market to the MTFs to ensure we have the proper case mix, this to include new ways of attracting Medicare-eligible or -aged patients, whether or not we actually define and establish a sort of Medicare Advantage within the MTFs.

We need to be given broader authorities, I think, that relate to taking care of veterans. I think, in fact, there is even an opportunity for us to take care of DOD civilians. And, in fact, you know, we have a lot of dual-eligible folks who, in fact, work for the Federal Government and they have TRICARE benefits. Well, why not allow them to use the TRICARE benefits within the MTFs?

See, I think this would lead to proper utilization of the MTFs, proper market management, meet the case mix-skill mix issue and actually allow us to deliver extraordinary service to the beneficiary population.

So those are some of the things. There are other things that we could talk about, but off the top of my head, that would be some of the things we would look forward to.

Mr. MACARTHUR. Let me explore one other. And I am happy to have any of you answer.

In the private sector, you have a constant dynamic interaction between the provider of health care and the financier of health care. It is largely how the private sector healthcare system has evolved, that tension between high quality of care and affordability. And everyone hates it, but it works well. You don't have that.

As you observed earlier, TRICARE is not insurance. We are the financier of health care on behalf of the American taxpayer, and you don't have that same daily dynamic interchange.

Can you achieve what I am talking about, what we have been talking about—can you achieve that without this two-party negotiation going on a day-to-day basis?

General HOROHO. I will take that one and share it down the road.

Each of us have to be fiscally solvent to be able to manage and run our healthcare facilities. And so we have very well-defined business plans. We have incentives where we incentivize our providers and clinicians for patient satisfaction for their care experience, for health outcomes, and then we also incentivize them for readiness.

So we have moved as we improve readiness. That is something that they get incentivized and financial rewards for that and moving even more so in a complicated system of looking at how do we really move towards outcomes and functional health.

So this movement from health care to a system for health is a huge culture change that your financial system has to be able to drive it and support it.

General EDINGER. Yes. I think really the answer to the question you pose is really the value-based approach to providing health care. And I think to do that we have got to define and consider and measure and manage the performance and value in all of its as-

pects. And so that is quality, that is safety, that is patient experience, but it is also cost and efficiency.

The performance management system that we built in the direct care system and the action plans that followed up the MHS review last summer are really focused on all the aspects of value, including cost and per-member per-month cost, those kind of things. We are now managing to that as a metric. So I think really the answer is value-based approach to providing care.

Admiral FAISON. And, sir, also adding into that flexibility, flexibility, as we had talked about earlier, and agility. Health care is dramatically changing and it is impacting the military because, as I shared earlier, 75 percent of our uniformed force were born after 1986.

How they make their healthcare decisions and what influences those decisions is fundamentally different than what influences us, as Baby Boomers. And so they pursue convenience and the experience of care and increasingly technology, having the agility to pursue value-based options.

Using those things without requiring them to come to a hospital for their care is fundamental to our success and really an operational imperative. So the things that you could do to help to give us that agility is where success is going to lie.

Mr. MACARTHUR. Thank you, Mr. Chairman. I appreciate your indulgence. I was making up for lost time earlier.

Dr. HECK. I appreciate your very informed questions.

So I agree with Secretary Woodson's comments about trying to attract more consumers of health care into our MTFs to provide a better training platform for our military healthcare providers to be better ready.

And I think that was really one of the places where the Commission missed the mark. Certainly, when they presented to us, they seemed to be focused on the idea of the MTFs being training platforms solely for combat casualty care, not realizing, as you well pointed out, General Horoho, that the vast majority of folks we treat are not traumatic injuries.

So the question is: If you get the authorities and the flexibility and the marketing campaign is successful to bring more lives into the MTFs, is there capacity within the MTFs to be able to absorb a higher patient volume, whether it is the may we go to a Medicare Advantage-type TFL [TRICARE for Life] product or we go out and try to allow DOD civilians to participate and receive care at the MTFs? Are you going to be able to absorb that increased patient volume? And will the cost associated with caring for those new patients keep your business plan in the black?

Dr. WOODSON. So let me start again. I think the Surgeons General really need to weigh in on this.

So, first of all, within the MTFs, we have fixed cost. So if we take care of one patient, the cost of care for that patient is extraordinarily high. If we take care of more patients, of course, the costs go down. And there are some built-in costs of readiness, which is the issue we are talking about in terms of maintaining skill and the graduate medical education program.

So the bottom line for me is that there is capacity. I think what we have been working on is retooling how we are thinking and how

we are managing to make the system clearly more efficient and to make us a preferred provider. And I will stop there and let the Surgeons General talk.

General HOROHO. And, sir, just in two areas with that, it would be very helpful to be able to have a diverse population that we could care for, but it is going to have to be tied to our readiness: What is the complex cases that we need to really to support our training programs and increase our medical readiness of our providers and the support staff?

With that, though, it is going to require a commercial financial system and a business intelligence system because both of those are capabilities that we don't have right now and we would need to be able do that so that we could bill for certain services.

General EDINGER. So the care that is needed to help enhance and support our readiness is specialty and inpatient care. And in Air Force hospitals, yes, sir, we do have capacity.

I think, as we potentially gain the ability to more effectively capture care, that is the kind of care we would want to capture. And so I think we would need to go about it in a way using the business intelligence systems where we were capturing the kind of care that is most relevant to our readiness.

And that is the kind of care where we have capacity. Our hospitals are fully enrolled and growing. Our primary care workforce is really not what we need so much on the readiness side as it is to pull in specialty and inpatient care.

Admiral FAISON. Sir, I would agree with the other panel members. We not only see unit costs go down as you see more patients, but there is an inherent efficiency in the staff so that you see more patients much more efficiently and you get better outcomes.

And so long-term costs are down because you are getting better outcomes and keeping people healthy. Short-term costs are down because you are not using as many things to take care of them in the short term. So I think there are inherent efficiencies to that.

We have capacity to do that. But, as General Edinger and General Horoho said, we have to be selective. So we don't want to recapture all of one thing. We only need to look at what exactly do we need for our mission and then go after those.

Business intelligence is critical for that, and we don't have that right now. And so I think that will be an important tool that we will need in our toolkit to go after those things.

Dr. HECK. Perfect timing.

Well, I want to thank all of you, one, for staying with us even though we started late, and for your answers to the questions here today. Obviously, we look forward to continuing to work with all of you to make TRICARE the premier healthcare provider in the Nation.

I want to again hail Lieutenant General Edinger to our group.

And farewell to General Horoho. It has been a pleasure working with you, and I am sure we will be talking to you soon.

This hearing is adjourned.

[Whereupon, at 4:16 p.m., the subcommittee was adjourned.]

APPENDIX

June 11, 2015

PREPARED STATEMENTS SUBMITTED FOR THE RECORD

JUNE 11, 2015

Opening Remarks – Chairman Heck
Military Personnel Subcommittee Hearing

Department of Defense Views on Recommendations from the Military Compensation and Retirement Modernization Commission on Military Health Care Reform

June 11, 2015

Good afternoon. I want to welcome everyone to this hearing to discuss the Department's views on the Military Compensation and Retirement Modernization Commission's recommendations for reforming the military health care system.

As we studied the Commission's recommendations over the past 5 months, we considered the views of our current and retired service members through the organizations that represent them. We heard mixed reviews about TRICARE and the military health system; however the consistent viewpoint is that TRICARE can and should be improved. We take their concerns seriously and will consider all views before undertaking any changes to the military healthcare system.

That being said, I do believe that we can all agree that the work conducted by the Commission identified weaknesses in the current system that give us an opportunity to focus our efforts as we discuss reforming the military health system. It is our duty as the Military Personnel Subcommittee to get at the root cause of the issues and help determine the best course of action to fix them.

Today is the first hearing where we will receive specific testimony from the Department of Defense on their reaction to the Commission's recommendations to improve health benefits for our service members and families. I am interested in hearing from our distinguished panel if they agree or disagree with the Commission's recommendations or if they have alternative suggestions for addressing the shortfalls identified by the Commission. In addition, I am interested in hearing the Surgeons General's views on how the recommendations would specifically affect the future of the military treatment facilities and the direct care system.

As I've said before, a guiding consideration for our work is to ensure that we can continue to recruit and retain the best and brightest in order to maintain the viability of the All-Volunteer Force and ensuring that we do not break faith with our service members, retirees and their family members.

Before I introduce the panel, let me offer the ranking member, the distinguished woman from California, Congresswoman Davis an opportunity to make her opening remarks.

PREPARED STATEMENT

OF

THE HONORABLE JONATHAN WOODSON, M.D.,
ASSISTANT SECRETARY OF DEFENSE
(HEALTH AFFAIRS)
AND
SURGEONS GENERAL OF THE MILITARY DEPARTMENTS

BEFORE THE

HOUSE ARMED SERVICES COMMITTEE
SUBCOMMITTEE ON MILITARY PERSONNEL

JUNE 11, 2015

Chairman Heck, Ranking Member Davis, Members of the Committee. Thank you for the opportunity to come before you today to specifically remark on the recent recommendations from the Military Compensation and Retirement Modernization Commission (MCRMC), as well as to discuss the state of the Military Health System (MHS), and our plans for the future. Our testimony reflects the shared perspective and vision of the entire MHS leadership team that is testifying before you today.

The Commission has performed a valuable service to the Department and the nation. The Commission's 18-month independent review reaffirmed many positive changes we are making to help enhance the Services' capability to recruit, train and retain America's All-Volunteer Force in the present and future, while supporting those who have served our Nation. In addition, it pointed out areas where we can do better. In many cases, we have come to similar conclusions about the challenges facing military medicine with the end of kinetic combat operations.

There were many important recommendations with which we concur, and have already moved into implementation. There were other recommendations that contained suggestions that matched actions that were already well under way. The Commission's endorsement of these approaches is both welcome and helpful.

The DoD Review Process of Commission Recommendations

After receiving the MCRMC's Final Report on January 29, 2015, the Department conducted rapid, comprehensive and concurrent reviews of each recommendation. In total, this review spanned more than six weeks, was conducted by more than 150 subject matter experts, and supported by three Federally Funded Research and Development Centers (FFRDCs) -- RAND, IDA and CNA. In addition, the Department collaborated with experts from the

Departments of Labor, Commerce, Education, and Veterans Affairs, as well as Offices of Management and Budget and Personnel Management, to ensure a holistic review. Senior leaders at every level of DoD reviewed and provided critical input.

As the Department's official response has made clear, the MCRMC's objectives are largely consistent with the Department's objectives in this complex but essential aspect of national defense, our military force. Where the Department differs, however, is how to best to achieve these objectives in some cases. Although the Commission's work covered a broad array of compensation and benefit issues, we will confine our remarks to those recommendations that focused on health matters.

Medical Readiness

Regarding the state of medical readiness, the Commission provided noteworthy assessments about the challenges we face in providing our military medical forces the appropriate opportunities to sustain the clinical skills required for wartime.

A major pillar of our military health system is maintaining the readiness of our military medical providers to support combatant commanders anytime and anywhere. This requirement is partially satisfied through the care provided to those who seek care within our military medical treatment facilities (MTFs). Other aspects of military medical readiness are supported through strategic partnerships with civilian and VA health systems through which many of our military medical providers supplement their readiness skills.

The Commission is correct in asserting that a number of military medical facilities do not have sufficient internal clinical volume or case mix to sustain these skills. The Commission is

also correct in concluding that the Department does not apply the same rigor to managing clinical aspects of joint medical capabilities as it does with other aspects of military capability.

We agree that combat trauma is an important capability that deserves special attention. Combat trauma readiness increases during conflict as medical personnel provide more casualty care than they generally do in garrison. Therefore, we are working on an enterprise-focused joint medical readiness management effort to guide resource allocation and tactics, techniques, and procedures in a way that promotes the continued sustainment of key medical capabilities during peacetime. Mitigation levers like strategic partnerships with civilian institutions and the VA, targeted patient throughput at MTFs that includes a planned marketing campaign to attract beneficiaries to use military hospitals for specific, complex surgical procedures, and investments in joint training are all part of our existing portfolio designed to address these challenges.

The Commission's recommendations relative to enterprise measuring and management of essential medical capabilities (EMC) are worth pursuing. We believe that the range of capabilities required to support the warfighter are broader than the Commission's emphasis on combat support and trauma care. We plan to define EMCs to include more than the specific trauma-related capabilities advocated by the Commission, and align those with operational readiness requirements. Consider the very different demand signal coming from our recent support to fight Ebola in western Africa and the demand signal coming from the counterinsurgency operations in Afghanistan. Furthermore, even in Operation Enduring Freedom (OEF)/Operation Iraqi Freedom (OIF) /Operation New Dawn (OND), 61% of those evacuated from theater were for disease related issues; of all medical encounters recorded in theater, 77% were for disease and non-injury concerns. These statistics are consistent with the history of medical needs in wartime.

Together with the Joint Staff Surgeon and Service Surgeons General, and assisted by Military-Department-led and Joint-Staff-facilitated working groups, the ASD(HA) will determine EMCs for reporting and will identify how to measure the EMCs. These EMCs will be validated through the Military Health System Executive Review (MHSER) to the Deputy Secretary of Defense for approval, after which they will be added to the standard Defense Readiness Reporting System. Thus, in much the same way that Services report unit readiness now, they will use existing reporting systems to report metrics depicting the inventory of ready EMCs as well as the health of the underlying pipelines that produce those capabilities.

The Commission also recommended the establishment of a Joint Readiness Command. The Department does not support the creation of an additional four-star combatant command, the Joint Medical Readiness oversight council (JMROC), and the J10.

In 2011, the Secretary of Defense established a Task Force on MHS Governance to assess the optimal organizational structure for military medicine. A Unified Medical Command was one of the options considered by the DoD Task Force. The Task Force determined that a new unified medical command would add to, rather than reduce, headquarters overhead. Existing Service medical headquarters would continue to be required and home station medical command and control would continue to be managed according to Service-specific governance models. Consequently, the Department believes that it currently has sufficient processes and governance structures to identify, track, and measure the readiness status of enterprise-wide and Service specific EMCs and therefore does not support creation of an additional new four-start combatant command.

The establishment of the Defense Health Agency and a comprehensive joint governance process has provided a viable and affordable way for the Department to leverage economies of

scale for those functions that are common among the Service Medical Departments. The Department of Defense has an effective means of jointly measuring, monitoring, and managing the readiness of the joint force. The MHS Executive Review (MHSER) council has been revitalized in the last two years – providing a team of senior military and civilian leaders from the Services, Joint Staff and major OSD staff agencies to oversee major policy decisions and operational performance of the MHS. In addition, the department will include the status of joint medical capabilities in the existing Deputy's Management Action Group (DMAG) on readiness that are co-chaired by the Deputy Secretary and Vice Chairman of the Joints Chiefs, as well as the quarterly readiness review to Congress starting in FY 2016.

DoD and VA Collaboration

The Department supports the goals of the Commission and is committed to working even more closely with the VA to achieve greater data interoperability, improve the transition of our Service members back to civilian life, increase the number of DoD/VA sharing agreements for health care delivery, and coordinate with VA to determine the subset of medications important to transitioning Service members. The opportunities for sharing are vast and should be implemented where they align with both Departments strategic plans, make good business sense and serve the needs of our beneficiaries.

The standardization of common medical services and reimbursement methodology between the two Departments positively expands on the current work of the DoD/VA Joint Executive Council (JEC). Likewise, ensuring that Service members who leave the DoD are able to continue on all DoD prescribed medications builds on the President's Executive Actions of August 2014.

The Departments have determined that interoperability of health information is a high priority. Both Departments exchange significant amount of health and personnel information with each other. In addition, both DoD and VA are increasingly purchasing more health services from the private sector. Thus, interoperability with a broader set of health system is an overarching objective and high priority for both Departments. The DoD is interacting with the Office of the National Coordinator for Health IT (ONC) at all levels and has participated fully in developing the new ONC Interoperability Roadmap. This work is foundational to the roll-out of the new DoD Electronic Health Record. The Department expects to announce our selection of an EHR vendor this year.

The DoD also supports continued efforts to solve the problem of access to needed pharmaceuticals for transitioning Service members created by different formularies in the two Departments. There has been substantial progress: the VA has a waiver process to immediately achieve the Commission's recommendation, and the President's August executive actions to address service member and veteran mental health and suicide prevention address the specific case of psychiatric drugs by providing a default assumption that VA will continue mental health prescriptions for transitioning service members.

Finally, reforms to the governance of the DoD/VA Health Executive Committee (HEC), aligned to five major business lines, provide clarity and focus to our sharing objectives. These changes will improve our integration efforts and better allow us to follow progress toward mutually established milestones.

TRICARE Extended Health Care Option (ECHO)

The Department supports the objective of expanding services available to family members with special needs. The stresses of frequent moves and repeated deployments make it hard for military families to care for family members with special medical or educational needs. While many state Medicaid programs provide highly valued support services, the level of support varies widely among the states and even within counties. More importantly, the waiting list for these services often approaches or even exceeds the average deployment length keeping these services out of the reach of many active duty families.

The Exceptional Family Member Program (EFMP) was created to alleviate some of these challenges. Specifically, active duty families enrolled in EFMP are eligible, based on qualifying conditions, for the TRICARE Extended Care Health Option (ECHO). ECHO, provides eligible active duty families with an integrated set of support services and supplies designed to reduce the disabling effects of the beneficiary's qualifying condition.

The Commission recommended improving support for dependents with special needs by expanding ECHO services to better align with those provided under state Medicaid waiver programs. Expanded services would be subject to the ECHO benefit cap of $36,000 per fiscal year, per dependent.

The Department supports expanded services for family members with special needs. We plan to implement two services recommended by the Commission this year (for respite care and incontinence supplies). However, we believe that the full package of proposed changes requires additional time to evaluate, including any associated costs. By December 2015, we will have a more comprehensive assessment of the viability of the other recommendations put forward.

TRICARE Program

Only one proposal from the Commission requires even further study – and that is the recommendation to significantly alter the military health benefit provided to all 9.2 million DoD beneficiaries. We agree with the Commission that we need to continue to improve the military health system. This remains a critical issue, and the Department will work with the Commission and Congress to develop additional reform proposals for consideration as part of the Fiscal Year 2017 Budget.

TRICARE is an exceptional health benefit, tailored to meet the unique needs of military families. We believe its customized approach accommodates the unique mission of the Military Health System, best supports our overall readiness objectives, offers comprehensive choice to military beneficiaries, and provides the same global, highly affordable benefit to everyone – whether an 18 year old newly enlisted Service member or the Chairman of the Joint Chiefs of Staff.

We acknowledge that elements of TRICARE can be improved. We are specifically working to improve access to care, and TRICARE's authorization and referral processes. We have recently released requests for proposal for the next generation of TRICARE contracts that will further streamline administration, and we have internal teams focused on near-term process improvements to access and referrals.

The health care reforms proposed in the Fiscal Year 2016 President's Budget are a good first step and offer service members, retirees, and their families more control and choice over their health care decisions. They keep the overall, and highly successful, TRICARE program intact. The Department is looking forward to working with the Commission and Congress on drafting additional legislative proposals for the 2017 budget that would enhance the FY 2016

TRICARE proposals to further achieve the goals of the Department and those of the Commission.

Our Joint Future

The Military Health System is a unique and indispensable instrument of national security. Its value has been proven time and again in deployed environments, in responding to infectious disease outbreaks around the world (most recently with Ebola in West Africa), in disaster response and in humanitarian assistance missions, and above all in the routine delivery of care every day to the special population of Americans who we are privileged to serve. This mission attracts to the military some of the most respected medical professionals in the world.

The MHS is a complex organization with readiness at the center of the MHS mission. It draws strength from that complexity. Our health care delivery system, our health benefit, our education and training system, our medical research and development programs, and our public health capabilities complement each other in supporting this mission.

Components of the MHS – our Army, Navy, and Air Force medical services – each have unique missions, tied to the roles and responsibilities of their parent Service. Their affiliations with their line units strengthen the system, rather than diminish it, and enable us to meet our requirements to both our combatant commanders in theater and our commanders in garrison.

There are also similarities in how the Services operate, and the new Defense Health Agency is working as designed – to bring common solutions to shared challenges. Over the last 18 months, the Military Heath System has introduced a modernized, enterprise-wide approach to managing its vast responsibilities. Our decision-making model is highly collaborative and effective. In pharmacy, health IT, medical logistics, health facilities, medical research, public

health, and more – our system is bringing a joint approach to clinical and business operations where it makes sense.

We have undertaken a comprehensive assessment of our military medical infrastructure. In order to optimize our military medical team, our future capital requirements must reflect changes that have affected all of American medicine, and we must match personnel resources with where our beneficiary populations reside, or where local community capability is absent. Where necessary, we will expand strategic partnerships with both interagency and civilian institutions in support of our mission.

The FY15 National Defense Authorization Act required the Government Accountability Office (GAO) to review the methodology used by the Department in the Modernization Study. Following GAO Review, we would like the ability to move forward with implementing reasonable steps to improve efficiency without further delay.

Our system is implementing recommendations that emerged from the Secretary's Review of the MHS that occurred in summer 2014 and culminated in the Secretary's Action Plan of October 1, 2014. Quality, accountable health care is the most consequential benefit a grateful nation owes its Service members and their families. We are committed to improve and deliver on that commitment.

We have strengthened policy and oversight of our patient safety and quality programs. We have implemented, or are implementing, a number of other system-wide initiatives to provide quality of care to all MHS patients. These initiatives include adoption of the Global Trigger Tool to establish more than one mechanism for capturing harm events; the expansion of surgical quality data collection and analysis to all Direct Care surgical facilities through our participation in the American College of Surgeons' National Surgical Quality Improvement

Program; and standardized MHS training to reduce variability in coding and documenting of care for mothers and newborns.

We have established 30 enterprise-wide measures of readiness, access, safety, quality, satisfaction, and cost. These include measures such as individual medical readiness, the average number of days to next available appointment (access), hospital acquired infection rates (safety), post-partum hemorrhage rates (quality), and satisfaction with getting care when needed. The ASD(HA), the Surgeons General and the Director, Defense Health Agency review these measures on a quarterly basis and share findings with the entire MHS community. We "drill-down" on essential core measures to drive improvement. I am encouraged by the direction in which we are moving along a number of measures, but there is much more to do.

We recognize that the patient is a partner in their health, not simply a customer. We have undertaken a long-term effort to increase transparency of health information. We have made it easier to find our existing, public information by consolidating quality, safety, access, and satisfaction measures in one location on our military health websites. In addition, we are in the midst of engaging with our beneficiaries to improve the usability of the information we place in the public domain. We are working with our partners at the Center for Medicare and Medicaid Services to participate in Hospital Compare. When unexpected events occur, we have a global Health Care Resolutions process in place to serve patients, patients' families, and our medical staff in understanding what happened through an open, ongoing dialogue.

The Department has proposed a number of other actions that help accelerate our reform efforts and allow us to serve as responsible stewards of government resources. Fiscal pressures both within the Department and with health care in general require continued close attention to how our financial resources are used. Several Department proposals are under consideration by

Congress at this time.

We have proposed updates to prescription drug co-payments that further incentivize use of MTF and mail order pharmacies, and are closer to civilian sector copayments. We will continue to provide prescriptions in MTFs with no out-of-pocket cost to beneficiaries. Current fiscal realities compel us to consider the TRICARE benefit, along with a full range of management improvements, to achieve the efficiency objectives of both the Commission and the President's Budget request. Failing to do this would compel DoD to take additional reductions in the areas of readiness, modernization, and force structure. In addition, as the military services are making force structure changes, we would benefit from the ability to convert some military medical authorizations to civilian authorizations when it supports our readiness needs and management efficiency.

The Military Health System does not exist for its own sake. As our military forces continue to operate in Afghanistan, confront the threats posed by ISIS, stand fast with our allies and partners in maintaining peace and stability in other parts of the world, and remain ready to respond to any contingency at any time, they know they are supported by a health system that will do everything in its power to ensure their health and sustain their lives, as well as that of their families.

We are fortunate to be entrusted with serving as stewards of this system of care. This system has enjoyed many successes and medical breakthroughs over the last 13 years of war – including advancements in sophisticated blood clotting agents or aeromedical evacuation capabilities for critically injured patients, providing "care in the air" that was previously beyond our capabilities. Where there are areas that require further improvement, we have identified them, and begun a sustained effort to get better.

We are grateful for this opportunity to present our findings, and our way forward, and we look forward to your questions.

Jonathan Woodson
Assistant Secretary of Defense (Health Affairs)

Dr. Jonathan Woodson is the Assistant Secretary of Defense for Health Affairs. In this role, he administers the more than $50 billion Military Health System (MHS) budget and serves as principal advisor to the Secretary of Defense for health issues. The MHS comprises over 133,000 military and civilian doctors, nurses, medical educators, researchers, healthcare providers, allied health professionals, and health administration personnel worldwide, providing our nation with an unequalled integrated healthcare delivery, expeditionary medical, educational, and research capability.

Dr. Woodson ensures the effective execution of the Department of Defense (DoD) medical mission. He oversees the development of medical policies, analyses, and recommendations to the Secretary of Defense and the Undersecretary for Personnel and Readiness, and issues guidance to DoD components on medical matters. He also serves as the principal advisor to the Undersecretary for Personnel and Readiness on matters of chemical, biological, radiological, and nuclear (CBRN) medical defense programs and deployment matters pertaining to force health.

Dr. Woodson co-chairs the Armed Services Biomedical Research Evaluation and Management Committee, which facilitates oversight of DoD biomedical research. In addition, Dr. Woodson exercises authority, direction, and control over the Defense Health Agency (DHA); the Uniformed Services University of the Health Sciences (USUHS); the Armed Forces Radiobiology Research Institute (AFRRI); the Defense Center of Excellence for Psychological Health and Traumatic Brain Injury (DCoE); the Armed Forces Institute of Pathology; and the Armed Services Blood Program Office.

Prior to his appointment by President Obama, Dr. Woodson served as Associate Dean for Diversity and Multicultural Affairs and Professor of Surgery at the Boston University School of Medicine (BUSM), and senior attending vascular surgeon at Boston Medical Center (BMC). Dr. Woodson holds the rank of brigadier general in the U.S. Army Reserve, and served as Assistant Surgeon General for Reserve Affairs, Force Structure and Mobilization in the Office of the Surgeon General, and as Deputy Commander of the Army Reserve Medical Command.

Dr. Woodson is a graduate of the City College of New York and the New York University School of Medicine. He received his postgraduate medical education at the Massachusetts General Hospital, Harvard Medical School and completed residency training in internal medicine, and general and vascular surgery. He is board certified in internal medicine, general surgery, vascular surgery and critical care surgery. He also holds a Master's Degree in Strategic Studies concentration in strategic leadership) from the U.S. Army War College.

In 1992, he was awarded a research fellowship at the Association of American Medical Colleges Health Services Research Institute. He has authored/coauthored a number of publications and book chapters on vascular trauma and outcomes in vascular limb salvage surgery.

His prior military assignments include deployments to Saudi Arabia (Operation Desert Storm), Kosovo, Operation Enduring Freedom and Operation Iraqi Freedom. He has also served as a Senior Medical Officer with the National Disaster Management System, where he responded to the September 11th

attack in New York City. Dr. Woodson's military awards and decorations include the Legion of Merit, the Bronze Star Medal, and the Meritorious Service Medal (with oak leaf cluster).

In 2007, he was named one of the top Vascular Surgeons in Boston and in 2008 was listed as one of the Top Surgeons in the U.S. He is the recipient of the 2009 Gold Humanism in Medicine Award from the Association of American Medical Colleges.

Lt. Gen. Patricia D. Horoho
Surgeon General of the Army

Lieutenant General Patricia D. Horoho assumed command of the U.S. Army Medical Command on December 5, 2011 and was sworn in as the 43rd Army Surgeon General on December 7, 2011. LTG Horoho has held every level of leadership in Army Medicine to include positions as Deputy Surgeon General; Chief of the U.S. Army Nurse Corps; Commander, Western Regional Medical Command; Commander, Madigan Army Medical Center; Commander, Walter Reed Health Care System and Commander, DeWitt Health Care Network; and as the Special Assistant to the Commander, International Security Assistance Force Joint Command, Afghanistan.

LTG Horoho earned her Bachelor of Science in Nursing degree from the University of North Carolina at Chapel Hill and received her Master of Science degree as a Clinical Trauma Nurse Specialist from the University of Pittsburgh. She is a resident graduate of the Army's Command and General Staff College and the Industrial College of the Armed Forces, where she earned a second Master of Science degree in National Resource Strategy.

Recognitions include selection in 1993 by "The Great 100" as one of the top one hundred nurses in the State of North Carolina. In the same year, LTG Horoho was selected as Fort Bragg's Supervisor of the Year. She deployed to Haiti with the Army's first Health Facility Assessment Team. In 1998, she co-authored a chapter on training field hospitals, published by the U.S. Army Reserve Command Surgeon. She was honored by Time Life Publications in December 2001, for her actions at the Pentagon on September 11. In September 2002, she was among fifteen nurses selected by the American Red Cross and Nursing Spectrum to receive national recognition as a “Nurse Hero.” In 2007, she was honored as a University of Pittsburgh Legacy Laureate. In April 2009, she was selected as the USO’s “Woman of the Year,” and in May became an affiliate faculty with the Pacific Lutheran University School of Nursing, Tacoma, Washington. In May 2010, the Uniformed Services University of Health Sciences appointed LTG Horoho as Distinguished Professor in the Graduate School of Nursing. She was awarded the National Society of the Daughters of the American Revolution Margaret Cochran Corbin Award in June 2010. In 2011, she was selected as the Alumna of the Year by the University of North Carolina School of Nursing. In 2012 she was recognized by the University of Pittsburgh as a Distinguished Alumna Fellow, and was awarded the Doctor of Public Service in Nursing, honoris causa. In June 2012, she was inducted as a Fellow of the American Academy of Nursing. In April 2013, she was presented with the Society of Trauma Nurses Leadership Award. She was awarded the Helen Manzen Award from the New York University College of Nursing for exemplary leadership on behalf of the health of the Nation in May 2013. In September, she was honored by the American Red Cross with the 2013 Women Who Care Humanitarian Award. In May 2014, she was conferred an honorary Doctor of Laws degree by the University of Minnesota Board of Regents. Also in May, she was conferred the degree of Doctor of Science, honoris causa, by the trustees of the New York Institute of Technology. She was also honored as the first military service member and nurse, to receive the New York Institute of Technology’s Riland Public Service Award. She currently serves as a member of the Uniformed Services University Board of Regents.

LTG Horoho’s military awards and citations include the Superior Unit Citation, Distinguished Service Medal, Legion of Merit, Bronze Star Medal, and France's National Order of Legion of Honor, Chevalier (Knight) Award.

Lieutenant General Mark A. Ediger
Surgeon General of the Air Force

Lieutenant General Ediger is the Surgeon General of the Air Force, Headquarters U.S. Air Force, Washington, D.C. General Ediger serves as functional manager of the U.S. Air Force Medical Service. In this capacity, he advises the Secretary of the Air Force and Air Force Chief of Staff, as well as the Assistant Secretary of Defense for Health Affairs on matters pertaining to the medical aspects of the air expeditionary force and the health of Air Force people. General Ediger has authority to commit resources worldwide for the Air Force Medical Service, to make decisions affecting the delivery of medical services, and to develop plans, programs and procedures to support worldwide medical service missions. He exercises direction, guidance and technical management of a $5.9 billion, 44,000-person integrated health care delivery system serving 2.6 million beneficiaries at 75 military treatment facilities worldwide.

Prior to his current assignment, General Ediger served as Deputy Surgeon General, Headquarters U.S. Air Force, Washington, D.C. where he directed clinical operations and quality of the Air Force Medical Service, aeromedical evacuation, global force management, readiness, strategic medical plans, programs and budget, medical force management and medical information systems management.

General Ediger is from Springfield, Missouri. He entered the Air Force in 1985 and has served as the Aerospace Medicine Consultant to the Air Force Surgeon General, commanded two medical groups and served as command surgeon for three major commands. He deployed in support of operations Iraqi Freedom, Enduring Freedom and Southern Watch.

EDUCATION

1977 Bachelor's degree in chemistry, University of Missouri, Kansas City
1978 Doctor of Medicine degree, University of Missouri, Kansas City
1981 Residency in family practice, Wake Forest University, Winston-Salem, NC
1991 Master of Public Health degree, University of Texas School of Public Health, San Antonio, TX
1992 Residency in aerospace medicine, USAF School of Aerospace Medicine, Brooks AFB, TX

ASSIGNMENTS

1986 - 1988 Chief, Family Practice, Air Transportable Hospital Commander, 1st Medical Group, Langley AFB, VA
1988 - 1990 Flight Surgeon and Chief, Flight Medicine, 94th Fighter Squadron, Langley AFB, VA
1990 - 1992 Resident in Aerospace Medicine, USAF School of Aerospace Medicine, Brooks AFB, TX
1992 - 1994 Chief, Aeromedical Services, 325th Medical Group, Tyndall AFB, FL
1994 - 1996 Chief, Aerospace Medicine Branch, and Chief, Professional Services Division, Headquarters Air Education and Training Command, Randolph AFB, TX
1996 - 1998 Chief, Aerospace Medicine Division, Air Force Medical Operations Agency, Bolling AFB, D.C.
1998 - 2000 Command Surgeon, Air Force Special Operations Command, Hurlburt Field, FL
2000 - 2002 Commander, 16th Medical Group, Hurlburt Field, FL
2002 - 2003 Commander, 363rd Expeditionary Medical Group, Southwest Asia
2003 - 2007 Command Surgeon, Headquarters U.S. Air Forces in Europe, Ramstein Air Base, Germany
2007 - 2008 Command Surgeon, Headquarters Air Education and Training Command, Randolph AFB, TX
2008 - 2012 Commander, Air Force Medical Operations Agency, Lackland AFB, TX
2012 - 2015 Deputy Surgeon General, Headquarters U.S. Air Force, Washington, D.C.
2015 – present Surgeon General, Headquarters U.S. Air Force, Washington, D.C.

FLIGHT INFORMATION
Rating: Chief flight surgeon
Flight hours: More than 800 hours, including 90 combat support hours and 38 combat hours
Aircraft: C-130, MH-53, F-15, T-38 and KC-135

MAJOR AWARDS AND DECORATIONS
Air Force Distinguished Service Medal
Legion of Merit with two oak leaf clusters
Bronze Star Medal
Meritorious Service Medal with four oak leaf clusters
Aerial Achievement Medal

PROFESSIONAL CERTIFICATIONS
1982 American Board of Family Practice (most recent recertification in 2015)
1992 Aerospace Medicine, American Board of Preventive Medicine

EFFECTIVE DATES OF PROMOTION
Major 28 April 1986
Lieutenant Colonel 28 April 1992
Colonel 28 April 1998
Brigadier General 14 April 2008
Major General 13 July 2012
Lieutenant General 5 June 2015

(Current as of 8 Jun 15)

Rear Admiral C. Forrest Faison, III
Deputy Surgeon General of the Navy
Deputy Chief, Bureau of Medicine and Surgery

A native of Norfolk, Va., Rear Admiral Faison received his Bachelor's degree from Wake Forest University and his medical degree from the Uniformed Services University of the Health Sciences. He completed post-graduate training in General Pediatrics at Naval Hospital San Diego and fellowship training in Neurodevelopmental Pediatrics at the University of Washington.

Faison assumed the duties of Deputy Surgeon General of the Navy (Chief Operating Officer) and Deputy Chief, Bureau of Medicine and Surgery in 2014.

Prior to reporting to this assignment, Faison served as Commander, Navy Medicine West and Naval Medical Center (NMC) San Diego where he was responsible for medical care and support to over 850,000 eligible beneficiaries by a staff of 16,000 at ten hospitals and over thirty clinics from the West Coast to the Indian Ocean. In addition to coordinating the Navy Medicine support response to Operation Tomodachi, he introduced several innovative programs in the region, improving health and fleet readiness, while decreasing overall healthcare costs, culminating in him being awarded the California Medical Community's Lighthouse Award for visionary leadership and inspiring health innovation, a first for the Department of Defense.

From 2009-2010, Faison served as Deputy Chief, Bureau of Medicine and Surgery, for Current and Future Healthcare Operations where he was responsible for policy and coordination of Navy Medicine healthcare facilities and operations worldwide as well as coordination of Navy Medicine response to the Haiti earthquake disaster and medical support activities to Navy and Marine Corps operational forces worldwide.

In 2007, Faison reported as commanding officer of Naval Hospital Camp Pendleton where he provided seamless disaster response and medical support during two Southern California wildfire disasters. Under his tenure, the command achieved its highest performance on Joint Commission surveys and was hailed as a model for emulation.

In 2006, Faison assumed command of U.S. Expeditionary Medical Facility - Kuwait and served as Commanding Officer, U.S. Medical Task Force – Kuwait where he led a tri-service task force of subordinate commands and was responsible for all healthcare operations in Kuwait, Qatar and Southern Iraq, and all medical logistics support throughout U.S. Central Command.

Other assignments include: Deputy Commander, Naval Medical Center Portsmouth, Portsmouth, Va.; Group Surgeon, 3d Force Service Support Group, Fleet Marine Forces, Pacific; Director of DoD Telemedicine, Washington D.C.; Chief Information Officer, Navy Medicine; U.S. Naval Hospital, Yokosuka, Japan; Naval Hospital Lemoore.; USS Texas (CGN 39); and Amphibious Group 3.

Faison is board certified in Pediatrics and is an Associate Clinical Professor of Pediatrics at the Uniformed Services University of the Health Sciences. He has several publications on neurodevelopmental outcomes of premature infants as well as other publications and book chapters on

the topics of the future of Wounded Warrior care and use of telemedicine and health informatics in healthcare. He is a senior member of the American College of Physician Executives. His personal awards include the Navy Distinguished Service Medal, Legion of Merit (5 awards); Meritorious Service Medal (3 awards); Navy/Marine Corps Commendation Medal, and Navy/Marine Corps Achievement Medal and numerous unit and other awards.

DOCUMENTS SUBMITTED FOR THE RECORD

JUNE 11, 2015

Statement

Of

The National Association of Chain Drug Stores

For

United States House of Representatives
Armed Services Committee
Subcommittee on Military Personnel

Hearing on:

The Department of Defense Views on the Military Compensation and Retirement Modernization Commission's Recommendations for Military Health Care Reform

June 11, 2015
2:00 p.m.
2212 Rayburn House Office Building

National Association of Chain Drug Stores (NACDS)
1776 Wilson Blvd., Suite 200
Arlington, VA 22209

Introduction

The National Association of Chain Drug Stores (NACDS) thanks the Subcommittee for the opportunity to submit a statement for today's hearing on the "Department of Defense (DoD) Views on the Military Compensation and Retirement Modernization Commission's Recommendations for Military Health Care Reform." NACDS and the chain pharmacy industry are committed to partnering with Congress, the DoD, and other healthcare providers to improve the quality and affordability of healthcare services for our nation's military heroes, retirees and their families.

NACDS represents traditional drug stores and supermarkets and mass merchants with pharmacies. Chains operate more than 40,000 pharmacies, and NACDS' chain member companies include regional chains, with a minimum of four stores, and national companies. Chains employ more than 3.2 million individuals, including 179,000 pharmacists. They fill over 2.9 billion prescriptions yearly, and help patients use medicines correctly and safely, while offering innovative services that improve patient health and healthcare affordability. NACDS members also include more than 850 supplier partners and over 60 international members representing 22 countries. For more information, visit www.NACDS.org.

As the face of neighborhood healthcare, community pharmacies and pharmacists provide access to prescription medications and over-the-counter products, as well as cost-effective health services such as immunizations and disease screenings. Through personal interactions with patients, face-to-face consultations and convenient access to preventive care services, local pharmacists are helping to shape the healthcare delivery system of tomorrow—in partnership with doctors, nurses, and others.

Recommendations of the Military Compensation and Retirement Modernization Commission

The Military Compensation and Retirement Modernization Commission (commission) heard from beneficiaries about the importance of healthcare provider choice and access. Accordingly, the commission strongly recommends patient choice, flexibility, access to care, and utilizing the latest healthcare innovations, such as medication therapy management (MTM). We are pleased that the commission recognizes that beneficiaries should be able to receive their prescriptions from whichever location they prefer, whether it be the local neighborhood pharmacy, a mail order facility, or a military treatment facility. Moreover, we applaud the commission for specifically recommending that the TRICARE pharmacy benefit should integrate pharmaceutical treatment with healthcare and to implement robust MTM.

Community Pharmacies are the Most Readily Accessible Healthcare Providers

Ninety-four percent of Americans live within five miles of a community pharmacy, making pharmacies among the most accessible healthcare providers. Local pharmacists play a key role in helping patients to take their medications as prescribed and offer a variety of pharmacist-delivered services to improve health quality and outcomes. With preventive immunizations and appropriate medication use, it is possible to reduce utilization of costly medical services such as emergency room visits and unnecessary physician visits. The proximity of community pharmacies to each and every American and pharmacists' exceptional knowledge and training renders pharmacies uniquely positioned to provide care for the American public.

Pharmacist-Administered Vaccinations Improve Public Health

Increasingly, local pharmacies are not only a reliable, convenient source for obtaining prescription drugs, but also a healthcare destination. For example, retail network pharmacies now provide vaccinations to TRICARE beneficiaries. Recognizing the cost

effectiveness of pharmacist-provided vaccinations, the DoD authorizes TRICARE beneficiaries to obtain vaccinations at a retail network pharmacy for a $0 co-payment. In its final rule expanding the authority of retail pharmacies to provide vaccinations, DoD estimated that in the first six months of the immunization program, it had saved over $1.8 million by having vaccinations provided through the pharmacy rather than the medical benefit (*Federal Register*, Vol. 76, No. 134, p. 41064). This cost savings did not take into consideration the savings from medical costs that would have been incurred in treating influenza and other illnesses if TRICARE beneficiaries had not been vaccinated. In addition, DoD noted in the final rule that "adding immunizations to the pharmacy benefits program is an important public health initiative for TRICARE, making immunizations more readily available to beneficiaries. It is especially important as part of the nation's public health preparations for a potential pandemic, such as was threatened in the recent past by a novel H1N1 virus strain. Ensuring that TRICARE beneficiaries have ready access to vaccine supplies allocated to private sector pharmacies will facilitate making vaccines appropriately available to high risk groups of TRICARE beneficiaries." (*Federal Register*, Vol. 76, No. 134, p. 41063).

Medication Therapy Management Improves Health Outcomes and Reduces Spending

MTM is a distinct service or group of services that optimize therapeutic outcomes of medications for individuals based on their unique needs. MTM services increase medication adherence, enhance communication and collaboration among providers and patients, optimize medication use, and reduce overall healthcare costs.

Policymakers have begun to recognize the vital role that local pharmacists can play in improving medication adherence. The role of appropriate medication use in lowering healthcare costs has been acknowledged by the Congressional Budget Office (CBO). The CBO revised its methodology for scoring proposals related to Medicare Part D and

found that for each one percent increase in the number of prescriptions filled by beneficiaries there is a decrease in overall Medicare spending. When projected to the entire population, this translates into a savings of $1.7 billion in overall healthcare costs, or a savings of $5.76 for every person in the U.S. for every one percent increase in the number of prescriptions filled.

Congress has also recognized the importance of pharmacist-provided services such as MTM by including it as a required offering in the Medicare Part D program. The experiences of Part D beneficiaries, as well as public and private studies, have confirmed the effectiveness of pharmacist-provided MTM. A 2013 Centers for Medicare and Medicaid Services report found that Part D MTM programs consistently and substantially improved medication adherence and quality of prescribing for evidence-based medications for beneficiaries with congestive heart failure, COPD and diabetes. The study also found significant reductions in hospital costs, particularly when a comprehensive medication review was utilized. This included savings of nearly $400 to $525 in lower overall hospitalization costs for beneficiaries with diabetes and congestive heart failure. The report also found that MTM can lead to reduced costs in the Part D program as well, showing that the best performing plan reduced Part D costs for diabetes patients by an average of $45 per patient.

The Medicare Payment Advisory Committee (MedPAC) has also been studying the effects of medication adherence in the Medicare program. In 2014, MedPAC released their findings for patients newly diagnosed with congestive heart failure. The findings showed significant medical side savings in both the high and low adherent population, compared to the non-adherent population (savings were greatest in the first six months).

A study of published research on medication adherence conducted by Avalere in 2013 concluded that the evidence largely shows that patients who are adherent to their

medications have more favorable health outcomes such as reduced mortality and use fewer healthcare services (especially hospital readmissions and ER visits). Such patients are thus cheaper to treat overall, relative to non-adherent patients. The study found that there was even wider range of cost offsets for patients demonstrating adherence to medications across particular chronic conditions.

How and where MTM services are provided also impacts its effectiveness. A study published in the January 2012 edition of *Health Affairs* identified the key role of retail pharmacies in providing MTM services. The study found that a pharmacy-based intervention program increased adherence for patients with diabetes and that the benefits were greater for those who received counseling in a retail, face-to-face setting as opposed to a phone call from a mail-order pharmacist. The study suggested that interventions such as in-person, face-to-face interaction between the retail pharmacist and the patient contributed to improved adherence with a return on investment of 3 to 1.

Americans rely heavily on their local retail pharmacies for a wide range of cost-saving services, including acute care and preventative services such as immunizations and MTM services. Beneficiaries that know and trust their local retail pharmacists for such services as immunizations are being forced to obtain medications from mail order facilities in remote locations with no opportunity for in-person consultation. There is no substitute for the pharmacist-patient face-to-face relationship. Community pharmacy services help to improve patient health and lower overall healthcare costs. Maintaining patient choice of how to obtain prescription medications is essential. For these reasons, NACDS urges adoption of the commission's recommendation to implement a robust TRICARE MTM program.

Preserving Patient Access and Choice in the TRICARE Program

As the commission found in its study of the program, TRICARE beneficiaries are concerned about being able to access the services they need. The commission heard from beneficiaries about the importance of healthcare provider choice and access and strongly recommended patient choice, flexibility, access to care, and utilizing the latest healthcare innovations in the TRICARE program. To address these beneficiary concerns and protect patient health, NACDS urges Congress to take steps to preserve access to the services beneficiaries need. Congress should delay the implementation of the FY2015 NDAA changes to the TRICARE prescription program as an effort is made to establish long-term solutions for the program that wouldn't harm patient care, such as creating acquisition cost parity across all treatment locations, including retail, Military Treatment Facilities (MTFs), and mail order. Presently, retail pharmacies that serve TRICARE beneficiaries have to pay much more for prescription drugs than mail order and military pharmacies. Creating acquisition cost parity will lead to greater savings for the DoD while at the same time ensure beneficiaries have access to the care and services they need. We believe that a provision for a pilot program included in the FY2016 NDAA (H.R. 1735) could potentially lead to long-term solutions for the TRICARE pharmacy program. "A TRICARE Pilot Program for Operation of Network of Retail Pharmacies Under TRICARE Pharmacy Benefits Program" would help ensure that retail pharmacy can continue to provide access to quality care and the important medication counseling services that only retail pharmacy can provide.

Last year's FY2015 NDAA mandated that many TRICARE beneficiaries would receive their prescriptions from MTFs or the TRICARE Mail Order Program (TMOP). The proposed pilot would examine the ability of retail pharmacies to provide improved access and lower costs in serving TRICARE beneficiaries. This pilot would also test allowing retail pharmacies participating in the pilot to purchase medication through the TRICARE Prime Vendor contracting process. The DoD currently purchases medications from its Prime Vendor at reduced rates for mail order and military treatment facilities

prescriptions. By allowing retail pharmacies in the pilot to access these medications at the reduced rate, the DoD will realize savings for prescriptions distributed via the retail setting. The savings achieved through leveling the playing field will allow TRICARE to increase access to retail pharmacies for beneficiaries. We believe the pilot will successfully demonstrate the ability of retail pharmacies to improve care, expand access, and save money.

NACDS urges Congress to allow for at least three initial prescription fills at the retail setting (90-day supply) for non-generic maintenance medications before requiring the use of a MTF or mail order. Allowing three initial fills would be in line with common commercial practices and would provide the beneficiary with ample time to make arrangements for home delivery. Finally, similar to the TRICARE for Life Pilot which was included in the FY2013 NDAA, beneficiaries should be given the opportunity to opt-out of the requirements to obtain brand name maintenance drugs at either a MTF or through mail order. In addition to preferring the convenience and service of their local pharmacist with whom they have a long-standing relationship, many patients benefit from having all of their prescriptions filled at one pharmacy location and from having face-to-face interactions with their pharmacist.

NACDS is opposed to the proposal in the President's budget to make additional changes to pharmacy co-payments that would further drive TRICARE beneficiaries out of their local pharmacies and to mail order. As noted above, there are already strong incentives in place to encourage beneficiaries to use mail order, nevertheless, the President's budget includes additional changes. Cost sharing will increase to as much as $46 for a 30-day supply of a formulary medication at retail, and as much as $92 for a 90-day supply of a non-formulary medication at TMOP.

In addition to unfairly penalizing TRICARE beneficiaries who prefer to use local pharmacies, NACDS believes that although this proposal may seem penny-wise, it is ultimately pound-foolish. Failure to take medications as prescribed costs the U.S. health system $290 billion annually, or 13 percent of total health expenditures, as estimated by the New England Healthcare Institute in 2009. Threatening beneficiary access to prescription medications and their preferred healthcare provider will only increase the use of more costly medical interventions, such as physician and emergency room visits and hospitalizations.

NACDS support sensible cost savings initiatives. Thus, we urge Congress to support TRICARE beneficiaries in obtaining their prescription medications at their local pharmacies. Doing so would decrease overall program costs while also preserving beneficiaries' health and wellness.

Conclusion

Thank you for the opportunity to share our views. We look forward to working with you on policies that control costs and preserve access to local pharmacies.

QUESTIONS SUBMITTED BY MEMBERS POST HEARING

JUNE 11, 2015

QUESTIONS SUBMITTED BY MR. JONES

Mr. JONES. In response to a congressional inquiry addressed to you, the Army reported that, in May 2014, General Horoho's office approved a business case analysis (BCA) submitted by HDRL to take all HIV testing services "in-house." In the months following this decision key assumptions of the BCA have proven to be incorrect. Current facilities have proven to be inadequate, test equipment, supplies and Army resources unavailable. These significant lapses led to the Army's delay in pursuing this for up to 3 years. It's also seems that the Army's effort to do this would result in sole sourcing with a company that has been heavily fined by the Justice Department, for bribing foreign government officials in order to obtain government business, in violation of the Foreign Corrupt Practices Act. (That company is Bio-Rad.) Bottom line, fundamental assumptions of the BCA have proven to be incorrect and the decision to take testing "in-house" needs to be reviewed as the evidence appears to indicate increased costs. Just as troubling the inferior performance of the proposed equipment, HDRL's track record on shipment and turn around and the inevitable uncertainties and inefficiencies associated with transition are cause for serious concern.

Secretary Woodson, General Horoho; are you reviewing this decision and if not, why not; and will you provide the committee with a copy of the original BCA, along with analysis addressing those areas mentioned above and any other areas where the BCA's assumptions have proven to be incorrect, as well as, provide details of the estimated costs associated with those changes. Thank you

Dr. WOODSON. The basic requirements of HDRL's BCA, which support the change in the Army's acquisition strategy for HIV testing, have not been significantly altered. Delays to date have been due to ensuring compliance with applicable policies and regulatory guidance, adherence to current contractual requirements, and addressing solicitation protests by the current contractor. The Army's current acquisition strategy is resourced, and is proceeding according to schedule barring any additional solicitation protests. HDRL's final costs within the BCA are currently under revision due to several procurement actions that are still out for bid. The Government's final cost for 4th Generation HIV testing is projected to be lower than the current contracted cost per test, which is based on a sole-source procurement to the incumbent contractor. All Army Procurements are done in accordance with the Federal Acquisition Regulations (FAR) and the Defense Federal Acquisition Regulation Supplement (DFARS). This includes ensuring that contract awardees are not currently suspended, debarred or otherwise ineligible from receiving any Government contracts.

HDRL is fully accredited by the College of American Pathologists (CAP), and has served as the DOD/HA HIV reference lab since 1987. HDRL performs all OCONUS HIV testing (60K HIV screen tests/year), 6K HIV viral loads/year of USA/USN infected personnel for confirmatory testing and clinical monitoring, and 1.2K HIV resistance genotypes/year for all DOD HIV infected Soldiers and beneficiaries. Under the current contract all CONUS HIV testing that screens POSITIVE must be shipped to HDRL for supplemental, confirmatory testing.

Under HDRL's BCA, greater efficiencies would be achieved with the Army's HIV testing algorithm through performance of both screening and confirmatory testing at a single location. This would facilitate a quicker turnaround time for the Government for confirmed results as HDRL would not have to wait for a contractor to ship samples that screen positive to HDRL for confirmation. There are no known systemic issues with quality or performance of either Bio-Rad or Abbott's 4th Generation HIV testing method. A review of the Safety and Effectiveness data submitted to the US Food and Drug Administration by Bio-Rad and Abbott for their 4th Generation HIV test methods demonstrates comparable analytic performance for both manufacturers that meets or exceeds the FDA's sensitivity (>99%) and specificity requirements (>99%) for HIV assays.

Currently, there are four open procurements actions. As the BCA contains contractor bid and proposal information, commercial vendor sensitive information, and source selection information related to these ongoing procurement actions, the release of the full BCA prior to final award would violate the Procurement Integrity

Act (PL 111–350, Section 2102 and FAR 3.104). Final award of the open actions is anticipated in mid-August 2015, and the BCA will be releasable at that time.

QUESTIONS SUBMITTED BY MR. WALZ

Mr. WALZ. Dr. Woodson, do you agree with the MCRMC Conclusion that "As evidenced by the similarity in benefits authorized under the HCBS and ECHO programs, as well as the directive to use state and local services before accessing ECHO, the Congress intended ECHO as an alternative to unavailable waiver benefits. Yet ECHO benefits, as currently implemented, are not robust enough to replace state waiver programs when those programs are inaccessible to Service members and their EFMs. With the exception of home health care services and ABA therapy services, the ECHO program is not highly utilized. This is due to a lack of needed services."?

Dr. WOODSON. The ECHO program, as currently implemented, offers a robust range of integrated services and supplies beyond those offered by the basic TRICARE health benefit program. These services and supplies include, but are not limited to, assistive services (e.g., from a qualified interpreter or translator), durable equipment (including adaptation and maintenance equipment), expanded in-home medical services (through ECHO Home Health Care (EHHC), rehabilitative services, respite care, training to use special education and assistive technology devices, limited transportation services to and from institutions or facilities, etc. The ECHO program was not designed to serve as a full replacement to state waiver programs, and as a result, there are significant differences between benefits authorized under the HCBS and ECHO programs. To assist DHA in better aligning ECHO services with HCBS, DHA has initiated an analysis of HCBS waivers and eligibility criteria, and is in the process of designing a beneficiary survey to identify current gaps in ECHO services and to evaluate which HCBS services should be added to the ECHO program to better support our military families.

Mr. WALZ. Dr. Woodson, do you agree with the MCRMC's recommendation that "Services covered through ECHO should be increased to more closely align with state Medicaid waiver programs, to include allowing for consumer-directed care."? If so, what is the implementation plan and timeline? If not, what alternative would you propose?

Dr. WOODSON. DHA is currently developing a beneficiary survey to identify current gaps in ECHO services and to evaluate which state Medicaid waiver services should be added to the ECHO program to better support our military families. Consumer-directed care (which is legally limited to respite and attendant care) is one avenue of service delivery that will be considered after the survey has been completed and the needs have been identified. To better understand how consumer-directed care might be effectively implemented under the ECHO program, DHA has met with the MCRMC research group to review the process for, and the impact of, the implementation of consumer-directed care in several states. Additional research in this area will occur over the next 4–6 weeks.

Mr. WALZ. Dr. Woodson, how can DOD in the immediate term, address the underlying objectives of increasing access, choice and value in military health care, specifically for families and children under TRICARE? Do the steps require legislation or does DOD already have the authority?

Dr. WOODSON. The Military Health System (MHS) is addressing access, choice and value in military health care through initiatives in primary and specialty care. The Patient Centered Medical Home (PCMH) model of primary care is our foundation for enhancing access, improving health and increasing quality. Currently, over 310 of our primary care clinics are recognized by the National Committee for Quality Assurance (NCQA) as meeting the highest PCMH standards. The PCMH model of evidence-based care supports the patient's continuous relationship with his or her primary care manager (PCM) and healthcare team, who coordinates and integrates the patient's care needs. PCMH also enhances access to care by offering alternatives to face-to-face medical appointments including walk-in clinics for common acute conditions, a Nurse Advice Line available 24 hours a day and secure messaging, which allows patients to email their PCM and healthcare team. To further improve access to care, the MHS has embedded specialty providers for commonly occurring medical issues directly in the PCMHs; these providers include behavioral health specialists, clinical pharmacists and physical therapist. PCMH is supported by two new access initiatives to ensure patient medical needs are addressed in a timely manner.

First, MHS is implementing policies, which identify standard processes for patients calling for appointments to ensure patients' needs are resolved on the first phone call. The MHS also is implementing Simplified Appointing Guidance, which

will better match primary care appointment supply by patient demand, especially for appointments available within 24-hours. Simplified Appointing guidance also identifies processes to appoint patients based on their preference for when they want to be seen rather than on the acuity of their medical condition. Simplified Appointing is based on best practices recognized by the Institute of Medicine. By leveraging the success of the Tri-Service PCMH program, the MHS is now developing standard processes and goal to improve access to specialty care in the direct care system. Finally, to expedite our patients' access to specialty care in the direct care system or in the TRICARE network, the MHS is now developing a streamlined specialty appointing process. DOD has the authority to accomplish required actions and steps do not require legislation.

Mr. WALZ. Dr. Woodson, one of the key recommendations in the MHS Review that was completed last summer stated "The Department will expand its collaboration with external health care organizations to improve as a learning organization". It is my understanding that senior leadership within the Defense Health Agency will be meeting with pediatric stakeholders, including the TRICARE for Kids Coalition, which includes, among others, the American Academy of Pediatrics and the Children's Hospital Association on the 24th of June. Using that meeting as an example, can you explain how you intend to take their input as it relates to pediatrics to improve "as a learning organization"? I would appreciate an out brief after the meeting, helping the committee understand what their recommendations are, and how you plan to incorporate their suggestions into ensuring we are providing excellent medical care for our military connected children.

Dr. WOODSON. The June 24, 2015, meeting did occur and we had great attendance with representation from about 10 different groups, to include the American Academy of Pediatrics, National Military Family Association, and the National Association for Children's Behavioral Health. Attendees were provided information on: (1) compound drugs, and informed that TRICARE is dedicated to getting safe, effective, and appropriate compound drugs to all beneficiaries, to include our pediatric population. (2) Pediatric Program Updates (e.g. changes planned for the Extended Care Health Option (ECHO) program (e.g. respite care and adult diapers for incontinence, breastfeeding supplies and services), and (3) TRICARE's benefits regarding mental health care for children.

We are committed to hosting two meetings a year with the group and will work to address their recommendations as they arise. We trust this will ensure we continue to provide excellent medical care to our military children.

Mr. WALZ. Dr. Woodson, similarly, when it comes to children, we hear that Medicaid and CHIP are the gold standard, in terms of the comprehensive coverage and the attention to pediatric health and development. What can you learn or adopt from those programs that will enhance and protect children's health coverage, particularly in order to create a program that responds to and develops in alignment with best practices and technology and treatment options as they are emerging and developing, so that the DHA is not always playing catch up in the children's health care arena. Do the steps require legislation or does DOD already have the authority?

Dr. WOODSON. Medicare and CHIP are not designed as specific uniform standards but rather are health insurance plans underwritten by the states for children in families with income up to 200 percent of the federal poverty level ($48,500 per year for a family of four). Eligible children and teens can receive regular check-ups, immunizations, doctor and dentist visits, vision care, hospital care, mental health services and medications. These services are different in each state with different requirements of income and necessity. All the medical services in Medicaid and CHIP are available and some more robust within the TRICARE entitlement programs. The alignment with emerging best practices, technology and treatment options require evaluation of the cost and legislative authority (Well Child Care defined up to age 5). With the statutory permission received from Section 704 from NDAA 2015, the DHA has been able to begin to design an enhanced approach to adopt and review emerging and developing technologies. This will continue to be strengthened through use of the governance system to review, evaluate and recommend benefit changes to address evolving beneficiary needs.

Mr. WALZ. Dr. Woodson, has the DOD calculated any comprehensive comparison of benefits and costs, including cost-shares and catastrophic caps, between the recommended TRICARE Choice plans and the current TRICARE plans? This is a big concern for families with special healthcare needs, active duty and retired. Does DOD have a plan to ensure that it can provide benefits (comparable to private plans and MA/CHIP as they relate to pediatrics) without increased or variable cost shares and catastrophic caps?

Dr. WOODSON. The current TRICARE Prime and TRICARE Prime Remote plans for Active Duty family members involve very minimal out of pocket costs (primarily for prescriptions which would be unaffected by the Commission's recommendation). Our analysis indicates that while the proposed Basic Allowance for Health Care (BAHC) equals or exceeds the average out-of-pocket costs, the financial risk for active duty family members varies considerably by eligibility status, family size, choice of plan selected, and health status (including for families with special health care needs). According to the Commission's report, nearly 1 in 6 Service member families will be negatively impacted financially. 50,000–100,000 families will experience unreimbursed out-of-pocket expenses of more than $1,000 above the BAHC, disproportionately affecting those paid the least. In addition, unlike housing expenses covered by BAH, health care expenses are unpredictable and highly variable. Without controls to ensure BAHC is saved for health care-related costs (deductibles, co-insurance, premium cost-shares, etc.), it is highly likely that some members will face significant financial hardships without the resources to meet them. As for non-Medicare eligible retirees, the Department estimates that in the steady state (20% of premiums) the average retiree family of three will experience an increase of $3,600 (FY 2014 dollars) in out-of-pocket expenses, significantly more than current out-of-pocket and much more than Department proposals that have been rejected in the past. The Department's proposals for PB 2016 allowed active duty family members to continue with an MTF managed option with the same low out-of-pocket costs as today. In addition, the proposal for retiree health care was estimated to increase the out-of-pocket cost for a family of 3 by less than $300 per year.

Mr. WALZ. How does DHA intend to monitor the ECHO plan to ensure it maintains this alignment with state Medicaid waiver programs as technology and best practices change in the future?

Dr. WOODSON. DHA already has expertise in the area of medical benefit policy development, which includes a well-established process for continually monitoring reliable evidence for evolving medical benefits and technology. DHA will establish a similar process to continually monitor future changes to state Medicaid waiver programs and to assess whether ECHO policy or benefit revisions are indicated.

Mr. WALZ. A recent study by DOD stated "Overall, 37% of military families with a special needs child reported they had heard of the TRICARE ECHO program." Why is reaching these families difficult and what are you doing to improve your outreach to these families?

Dr. WOODSON. DHA currently utilizes a wide range of contemporary communication techniques to inform beneficiaries and providers about all aspects of the TRICARE program. However, this study suggests a need for additional emphasis on the TRICARE ECHO program to ensure that military families are fully informed of the process for participating in the ECHO program so that a family member with special needs can receive integrated services and supplies beyond those offered by the basic TRICARE health benefit program. DHA will explore options for providing focused ECHO messages under the current and future TRICARE contracts. These outreach efforts will include military families, primary care managers and other providers in the Military Treatment Facilities (MTFs), and network providers participating in TRICARE Managed Care Support Contracts. Additionally, DHA will reach out to the Services to ensure that Exceptional Family Member Program (EFMP) program coordinators are familiar with the ECHO program and can advise military families accordingly.

Mr. WALZ. The same report noted "72% of military families whose child was enrolled in TRICARE ECHO were satisfied or very satisfied with the program". What is the trend in satisfaction since the ECHO program was created? Is this a high number or a low number? Do you think the MCRMC recommendation would improve satisfaction with the ECHO program?

Dr. WOODSON. DHA regularly conducts various inpatient and outpatient beneficiary satisfaction surveys; however, ECHO program satisfaction is not routinely tracked by the agency. Therefore, DHA is unable to provide information on ECHO program satisfaction trends, nor can DHA state with certainty whether 72% represents a high number or a low number. However, Gallup researchers conduct annual surveys on a wide range of health care satisfaction metrics, including overall patient satisfaction with their health care coverage. Based on survey results from 2001 through 2012, between 63% and 72% of patients who were surveyed rated their overall satisfaction with their health care coverage as "excellent" or "good" (the other rating options were "fair" and "poor"). Although these surveys are not limited to patients with special needs, as an indicator of overall program satisfaction, it would appear that a 72% ECHO program satisfaction rating is consistent with the upper range of overall patient satisfaction with their health care coverage. DHA is committed to quality improvement and is currently developing a beneficiary survey

to identify gaps in ECHO services. The results of this survey will be used to evaluate which HCBS services from the MCRMC recommendation should be added to the ECHO program to better support our military families. This identification of coverage gaps and the subsequent implementation of necessary policy and program changes to better align the ECHO program with the MCRMC recommendation should lead to improved beneficiary satisfaction.

Mr. WALZ. What actions is DOD taking or contemplating to increase access to specialty care—which the MCRMC identified as a big challenge for families? Do the steps require legislation or does DOD already have the authority?

Dr. WOODSON. The Military Health System (MHS) is improving access to specialty care in both our direct care system and in our TRICARE network. The MHS Review of Access, Quality and Safety recommended leveraging the success of the Tri-Service Patient Centered Medical Home (PCMH) program to develop standard processes and goals to improve access to specialty care in the direct care system. Recapturing specialty care to the direct care system supports our goals of maintaining a ready military medical force, which is able to respond quickly and effectively in support of National Strategy. Our direct care PCMHs using evidence-based clinical practice guidelines (CPGs) to deliver more comprehensive, coordinated care in primary care without having to refer the patient to specialty care, which frees up specialty care access. In addition, the MHS has embedded specialty providers in PCMHs for commonly occurring medical issues directly so patients can be seen quickly without a referral; these providers include behavioral health specialists, clinical pharmacists and physical therapists. Our telehealth program also is expanding the reach of direct care specialists by providing tele-consultations to remote PCMHs, which do not have in-house specialty care capabilities.

To achieve the goal of improving access to specialty care and in support of our integrated delivery system, the MHS has developed a new Tri-Service Specialty Care Advisory Board. Our direct care specialties are increasing the number of available appointments as well as maximizing the availability of operating rooms and other support services. If specialty care is not available in the direct care system, patients will be referred to high quality specialty care in our TRICARE network. Our specialty care access standard is for patients to be seen for an appointment within 28 days and care in most specialties is available well within this access standard in both the direct care system and in the TRICARE network. Some specialties are in short supply nation-wide; however, the MHS ensures patients needing care are seen as quickly as possible. Finally, to expedite our patients' access to specialty care and in response to patient feedback, the MHS is now developing a streamlined specialty appointing process so patients know when and where they will be seen more quickly. DOD has the authority to accomplish required actions and steps do not require legislation.

Mr. WALZ. Children's behavioral health care seemed to be a particularly difficult area, due to the unavailability of outpatient providers, the obsolete model of residential treatment that TRICARE imposes, and the lack of some intermediate service levels. How is DOD addressing this shortfall? Do the steps require legislation or does DOD already have the authority?

Dr. WOODSON. Many of the challenges TRICARE faces regarding behavioral health care for children parallel the nationwide problem of appropriate care for this population, to include the shortage of outpatient providers, child psychiatrists and psychologists; access to residential treatment and partial hospital programs for substance use disorders; and appropriate services in between the two levels of care. TRICARE has several efforts underway to improve behavioral health care for our beneficiaries. In 2014, TRICARE regulations were finalized to add TRICARE-Certified Mental Health Counselors as authorized independent providers of mental health care. Also in 2014, the Department sought legislative relief to remove statutory quantitative limits on inpatient psychiatric and residential treatment center care for children in the TRICARE program. As a result, the National Defense Authorization Act for Fiscal Year 2015, Section 703 "Elimination of inpatient day limits and other limits in provision of mental health services" amended section 1079 of Title 10 United States Code to remove these quantitative limits, and we are currently revising our TRICARE program manuals to implement these changes. Additionally, the Defense Health Agency is in the process of drafting proposed regulatory changes to ensure our mental health benefit has parity with the benefits for medical/surgical procedures, is consistent with current industry standards of care, and facilitates access to qualified institutional and professional providers of mental health services. We anticipate that a proposed rule outlining these changes will be published in the Federal Register in the near future, and we will encourage stakeholders to provide feedback during the public comment period.

In addition to medical services, non-medical services continue to be available to all TRICARE eligible beneficiaries. Non-clinical counseling programs and resources are sponsored by the Services (such as the Army's Strong Bonds program and the Navy's Project Focus) and by Deputy Assistant Secretary of Defense for Military Community and Family Policy (such as Military Family Life Consultants, Military OneSource Programs, and the Joint Family Support Assistance Program). These adjunct programs, in addition to Military Health System behavioral health care, help ensure that children and families have access to a broad range of psychological services.

Mr. WALZ. If DOD does not agree with the MCRMC recommendations, what are some of the elements of private health plan design and administration that can be adopted to address the concerns so compellingly set forth in the MCRMC report? Do the steps require legislation or does DOD already have the authority?

Dr. WOODSON. The Department believes that adopting the proposal set forth in the 2016 President's Budget has many of the elements of most private health plans. That proposal would replace the two TRICARE plans (PRIME, Standard/Extra) with a simplified Preferred Provider Organization (PPO) plan. In 2014, 58% of beneficiaries covered by employer-sponsored insurance were enrolled in a PPO. In a PPO, beneficiaries have the choice to choose their providers. There are no requirements for referrals and authorizations, which is a source of many access-related complaints associated with TRICARE. Also, co-pays will differ to steer patients to the lower cost providers. In the PB 2016 proposal, co-pays were lowest for military treatment facilities (where patients are needed for our active duty providers), low for network providers (where the Department has lower costs) and highest for out-of-network care. Furthermore, copays are zero for preventive services, lowest for primary care, higher for specialty care and highest for emergency room visits.

While the PB 2106 proposal does require legislation, we are looking at options to address other aspects of the MCRMC report that will not require legislation, including implementing value based purchasing. The Department is reviewing those options now.

Mr. WALZ. The 2013 NDAA, Sec 735 directed "The Secretary of Defense shall conduct a study on the health care and related support provided by the Secretary to dependent children." The report was to include the (1) the findings of the study; (2) a plan to improve and continuously monitor the access of dependent children to quality health care; and (3) any recommendations for legislation that the Secretary considers necessary to maintain the highest quality of health care for dependent children. The findings of the study were published almost a year ago, in July 2014, but we still don't have a plan or recommendations for legislation. When do you anticipate providing this information?

Dr. WOODSON. Defense Health Agency began a Pediatric Integrated Project Team (IPT) in March to address the gaps and areas of consideration in the 2013 NDAA, Sec 735. This team is addressing each of the areas in the nine original elements in a multidisciplinary collaborative group from direct care, purchased care and other Department of Defense Agencies. The group is reviewing advocacy group responses to the 2013 NDAA Sec 735 for additional input and recommendations. The report from this group is anticipated to be reported to DHA governance in December 2015.

Mr. WALZ. General Horoho, one of the reasons the commission recommended changing the Military Health Care system is because military families and retirees told them they wanted choices. If your members do want more choice, is the Commission's recommendation what the members of your organization want? Do they believe choice will improve medical care? What are your concerns with the recommended change? Are there ways to improve the TRICARE program instead? If so how?

General HOROHO. The Army supports the Commission's objectives to increase choice for beneficiaries; however, we believe the DOD proposals in the 2016 President's Budget will achieve these goals without jeopardizing the ability to maintain a ready and deployable medical force and a medically deployable force. We are concerned that the Commission's proposal to establish a Federal Employee Health Benefit type program for beneficiaries risks loss of beneficiaries from the direct care system that provide the volume and complexity to sustain the skills of our military healthcare providers. The PB16 proposal offer Active Duty Family Members and Retirees the choice of using Military Treatment Facilities or network providers and incentivizes use of the direct care system. This creates choice as recommended by the Commission while preserving the case load required to sustain skills for our military providers. Additionally, Army Medicine must maintain the ability to provide critical healthcare services not available to our beneficiary population in the civilian market, for example, School-based Behavioral Health Care. Many of the Commission's goals are currently being achieved through initiatives such as patient-

centered medical home, nurse advice line, shared services, Defense Health Agency, and MHS governance. In order to improve the TRICARE program, the Army recommends expanding authorities to increase patient populations and therefore the case mix to keep military providers ready to deploy; seeking cost effective solutions to improve healthcare coverage of Reserve Component Families impacted during activation of Reserve Component Soldiers; and exploring strategies to transition from a fee-based health plan to a value-based health plan that incentivizes preventive care, improves health outcomes, and encourages healthy behaviors.

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